Interreg
Alpine Space

Policy Guidelines and Toolkit

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1. Objective of the Policy Guidelines

Existing regulatory framework: what are in each partner country/region the existing regulations and laws which concern, directly or indirectly the FCN? Is there anything new that the Consenso experience brought to the implementation of the exixsting regulations? What **improvements** can be foreseen based on the Consenso findings?

Providing the public and private operators of the cooperation area with a **toolkit** means recognising the regulatory baseline and offering the most adequate tools for each national/regional context. In

the light of that, it can be that in a specific domain, the most adequate intervention is at the human capital/training level, or at the FCN implementation model level, or at the social business model development level. Or even a combination/integration of the three tools.

Therefore, the elaboration of the output will first integrate the description of the legal/regulatory framework of the different partners, including a first evaluation of the impact of Consenso on such framework. The human capital training systems, the model of FCN-based care services, the social business model definition, as emerging results of the project, will be then described and modulated in the shape of usable tools by public/private operators. And finally the corresponding **policy recommendations** will be formulated.

2. Context

a. CoNSENSo project

The CoNSENSo project "COmmunity Nurse Supporting Elderly iN a changing SOciety" aims to develop a care model that puts the elderly at the centre of health and social services, building on the crucial role of the family and community nurses. The project will focus on improving and promoting human relations to allow the elderly to live at home as long as possible.

The project partners will not only develop specific training for nurses, work on new business models, but will pilot the social and health care model in five areas in the Alpine Space territory.

The creation of new public policies around this social innovation model is expected to be the main result of the project.

b. Alpine Space programme

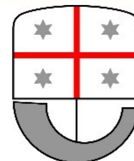
The Alpine Space programme connects actors from various sectors and different policy levels from the programme's 7 countries. They cooperate to tackle common challenges, exchange ideas and develop new working methods, with the aim of influencing policy-making. Sharing their experiences and expertise they work towards improving the quality of life for 66 million people in one of the most unique areas of Europe. Actions supported by the programme help to make the Alpine Space more innovative, CO^2-friendly, better connected and they contribute to an improved governance.

The programme is financed through the European Regional Development Fund (ERDF) as well as through national public and private contributions of the partner states. Projects can be co-financed through ERDF at a rate of up to 85%. For the 2014-2020 period, the total budget is €139 million.

c. Project partners

The project brings together 10 partners from 4 Alpine Space countries (Austria, France, Italy, and Slovenia) and 7 observers representing governmental ministries, health authorities and professional associations from the Alpine Space area. The project lead is the Health department of the Piedmont Region.

artners

Austria	France	Italy	Slovenia
		 Project lead	
			

Observers

Baden-Württemberg

KABEG
LKH VILLACH

KABEG
LANDESKRANKENANSTALTEN
-BETRIEBSGESELLSCHAFT – KABEG

KABEG
KLINIKUM KLAGENFURT
AM WÖRTHERSEE

d. Overall project objectives

People are living longer and longer and most wish to stay in their own homes. However, housing is not necessarily adapted for the elderly, and they may live in remote and isolated areas where public health and social services are limited. This is particularly the case in the Alpine space zone. The main idea behind the CoNSENSo project is therefore to create the conditions to improve health and life quality enabling the elderly to stay at home. This will be achieved through the development of a new model of care for senior citizens based around a Family Community Nurse. Moreover, the project will work towards three specific objectives:

- **Building** through training, an innovative **model for health & social care** for senior citizens
- **Evaluating** through 5 pilot areas, the new **model for health & social care** for senior citizens
- **Building capacity** for entrepreneurship through stimulating **social enterprise development** by nurses

The present output resumes the key elements CONSENSO approached and investigated in order to set out standards on training (chapter 3) and evaluating (chapter 4) FCN's activities. The main results of the project is the improved access to services for ageing citizens by validating this innovative model based on FCN. Furthermore the project intended to offer a model to power-up a social market economy approach (chapter 5).

The present output means to recommend a new governance to deliver healthcare and prevention, reducing health expenditure by cutting hospitalization costs thanks to FCN's activities. Transnational and multilevel governance evidence (chapter 6) will raise the capacity of PAs and social sector to "re-invent" themselves and deliver innovation in services.

3. The training model of CONSENSO

a. Contest

The CoNSENSo project "COmmunity Nurse Supporting Elderly iN a changing SOciety" aimed to develop a care model that puts the older people at the centre of health and social services, improving and promoting the relationships among senior citizens and the primary care professionals. The project focused on sustainable strategies to allow the older people to live at home as long as possible, building on the crucial role of the family and community nurses working proactively in rural areas.

e. State of the art

It is a matter of fact that the quality and success in caring for older adults relies on well-trained professionals. The WHO World reports on Healthy Ageing in 2015 and the WHO "Integrated Care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity" in 2017 highlighted that at present health professionals are unprepared to deal with the health-care needs of older adults. In fact, many training programmes were developed in the 20th century, when acute infectious diseases were prevalent health problems. Furthermore, curricula frequently overlook gerontological and geriatric knowledge and training and may lack guidance on managing common problems, such as multimorbidity and frailty. Despite the evidence that a holistic approach is most effective when caring for older people, health workers are still not trained to proactively anticipate and counter changes in function, looking at older person's priorities and helping them to increase control over their own health. Nurses' traditional curricula at undergraduate level do not equip them with the required knowledge to care for ageing people and consequently with the skills to consider in their daily activity effective preventive intervention. It is known that ageist stereotypes could affect the assessment of the older adults' needs if treatable disorders are dismissed as being normal parts of ageing. Moreover, the geriatricians consider frailty in older adults as a malleable and reversible condition. Frailty is a new emergent and promising concept to prevent disability, but the topic is poorly known in the Primary Care setting. The importance of frailty prevention has been recognized by the European Commission that has set up the Joint Action ADVANTAGE involving 34 member states to tackle the problem.

Moreover, new communication and care strategies considering Information Communication Technologies ICT, are core to the sustainability and development of the present health and social care services and the delivery of e-health assistance.

f. Training model

The CoNSENSO Project set at the base of the field activities an innovative learning paths enabling the family and community nurses to think critically and creatively, to act proactively with and to empower and engage person, families and communities to foster active and healthy ageing at home. A propaedeutic five-day training was carried out in Izola, Slovenia for all CoNSENSo nurses involved in the project implementation and for the training providers. This week was core to set the common bases and a unitary vision of the project activities according to the different primary care organizations of the partner countries.

The work package WPT1 led by the University of Primorska, Slovenia, developed the "Training Model" following the ADDIE steps: Analysis: assessing traditional curricula, assessing training needs, specifying objectives in each country, guiding training design and delivery, and developing success criterion.

Design: developing learning objectives, performance measures, and the progression of the training program.

Development: revising the training plan formulated in the design phase, and removing weaknesses.

Implementation: local training programme

Evaluation: assessing the effectiveness of the training.

The Co.N.S.E.N.So. training programme was developed on the bases of:

- The documents that propose the competences that the nurses should gain with the undergraduate studies of nursing: the European Commission Directive 2013/55/EU that amended the Directive 2005/36/EC; the European Federation of Nurses associations EFN guidelines for implementation of the Article 31 on the mutual recognition of professional qualifications, Brussels 2015; the Nursing and Midwifery Council Standards of Competence for Registered Nurses;.

- The Family Health Nurse Context, Conceptual Framework and Curriculum of the World Health Organisation (WHO, 2000), a curriculum designed to prepare qualified and experienced nurses for the new role derived from the WHO-EU Health 21 definition of the multifaceted role of the Family Health Nurse.
- The European Family Health Nursing Project (FamNrsE), funded by the European Union Lifelong Learning in 2011 that was a revitalized World Health Organization initiative involving Armenia, Austria, Germany, Italy, Poland, Portugal, Romania, Slovenia, Spain and Scotland. The project lead to a definition of family health nursing, required core competencies and capabilities, and consequent education and training requirements to tackle the global health challenges. A MSc In Family Health has been launched in Scotland on the project results.
- The International Council of Nursing guidelines for the community and family nurse.
- Overview of the competences of nurses achieved thorough undergraduate study programmes in some European Countries.

- Overview of postgraduate advanced studies for nurses:
    1. The Spanish Family and Community Nurses specialty programme, a 2-year postgraduate education to become a specialist in Family and Community Nursing;
    2. The PGD (Master of I level) of the University of Turin in Family and Community Nursing delivering 60 ECTS launched since 2005 and that has been recognized as good practice by the European Commission to award Regione Piemonte as Reference Site in the European Innovation Partnership on Active and Healthy Ageing (EIPonAHA); The Master of Science In Family Health launched in Scotland at the end the European Family Health Nursing Project (FamNrsE), that modulate the programme form PGD to the Master of Science;
    3. The Austrian PGD in Family and Community Nursing delivering 90 ECTS;
    4. The Australian training study programme, developed by Hua Mei Training Academy in Australia on Community Gerontological Nursing.
- The comparison among the local implemented CoNSENSo training programmes in the four partner Countries: Italy, Austria, France, and Slovenia.
- The predicted competences that a community and family nurse older adults should have, defined by project partners through the questionnaire prepared by PP7.
- The Five day training for the Co.N.S.E.N.So. Nurses lead by the Primorska University in Izola.

The basic idea (purpose and objectives) of the training programme is that the epidemiological and demographic changes and challenges require generalist-specialist professionals able to identify and assess the health status and the needs of individuals and families or caregivers in their cultural context and in the community. Furthermore, to reach the goals of the CoNSENSo Project, the nurses ought to be able to communicate effectively to promote health with individuals and communities; to support the empowerment and engagement of citizens; to identify personalized strategies to prevent or slow down the intrinsic capacities decline, the onset of frail conditions and disabilities in older adults; to assess risks of health conditions and needs of house adaptation to improve quality of life and safety; to propose innovative and sustainable health and social care solutions to families with special needs; to activate the network of services fostering the integration of care, and to identify and propose appropriate e-health solutions. The development of an "ad hoc" application to collect, process and monitor the needs of the older people living at home and the interventions proposed was included in the project and the nurses were trained to use it on their tablets.

g. Actors involved

During the project the education providers were: the University of Applied Sciences Upper Austria for Austrian Nurses, the Regional Centre of Vocational Training (C.R.F.P.) of the Red Cross for the French Nurses, the University of Turin for the Italian nurses, the University of Primoska for the Slovenian nurses. The academic training delivered a Post Graduate Diploma in Family and Community Nursing. Despite some differences in the planned and performed trainings, all the programmes were successful to provide the CoNSENSo nurses the knowledge and the competencies required for the implementation of the model in practice. Italian and Austrian partners stressed the importance of e-health competencies to foster sustainability of care delivery. Slovenian partners highlighted the importance of data security. Austrian partners included in their training the acquisition of

competencies to understand the health and social legislation. In all the partner countries, the common fields of key competencies listed by the partners are health promotion, public health, health education, communication.

All the partners see the potential of the training programme to be further developed as a transnational master, or as a specialization study programme in the field of nursing as well as life-long learning study programme for nurses and of other health and social care professions as well.

Nevertheless, the Master of Science in Family and Community Nursing appears to be the most suitable format to address the challenges of the health and social care in the present and future scenario of European Countries. Multi-professionals training is also recommended.

As a proper training is a core to take care properly of older people, it is suitable that the education is provided by academic institutions, as recommended by the European Commission Directive 2013/55/EU that amended the Directive 2005/36/EC.

4. Family and Community Nurses Model validation

a. Scenario

The goal of the evaluation report was to systematically present the results of the project CONSENSO and the key benefits that the project brought to local communities and their older residents. The CONSENSO project's overarching goal was to enable and empower the elderly to live at home as long as possible by introducing a FCN in their lives as a key person who can identify the needs of the elderly and intervene or organise support in the form of various services. In order to achieve this goal, project partners developed the CONSENSO model of intervention and tested it in five different Alpine Space regions - Carinthia, Liguria, Piedmont, Slovenia and Var. The main target group of the CONSENSO were older adults (aged 65 years or more), living predominantly in rural/remote areas. On the one hand, these areas experience more pronounced population ageing in comparison to urban areas, and on the other hand they are less equipped to tackle challenges linked to this process. Additionally, the services infrastructure (transport, health and social services, programmes, NGOs) in these is inadequate and have caused reduced mobility, a lack of support and care, social isolation and unfavourable socio-economic conditions. The CONSENSO project therefore began to identify the most vulnerable parts of this population and worked actively with individuals with different needs and conditions.

h. Methodology and results

In the study, the mixed-method design was used when collecting data. Qualitative methods were embedded within the quantitative design and played a role of supporting and additionally interpreting quantitative results. Since scientific research of experiments such as the CONSENSO pilot should be executed according to rigorous criteria, the control and experimental group should have been an essential part of the scientific method. CONSENSO project ensured comparative analysis of the control and experimental group in the region of Piedmont. The results tend to show the most pronounced effects of the action in exposed males, in the lower age ranking and with a higher level of education, suggesting that model implementation has obtained better results, in terms of more substantial changes, among subjects usually less attentive to prevention like males. After CoNSENSo implementation propensity to change was more frequently observed among less aged elderly, probably due to higher cognitive and physical resources, and among the most educated ones, who probably have higher capacity to access and use the services. It is premature to state that changes in direction and intensity observed are fully attributable to the work of CoNSENSo's family and community nurses and that other factors have not led to changes. However it must be underlined

that in the group of elderly residing in matched areas changes have been milder or with directions that tend to follow the more general medium-long term trends of the Piedmont's population.

In other regions the control group was not available, therefore only perceived differences in the everyday lives of the individuals were described. In the three years of project implementation (December 2015 – December 2018), partners had a challenging task of designing a new model of care, preparing an application for collecting data on tablets from scratch, delivering tools and evaluation instruments, organizing field work, sensitizing local communities, promoting the project and interventions and performing numerous visits to clients with an ambitious goal of improving their lives. The initial part of the project was especially demanding since the project partners had to combine various ideas, national (macro level) needs and characteristics, legislations, interdisciplinary differences in the understanding of the community care, all in order to develop a uniform model of interventions at home. Some methodological issues, related to the common understanding of indicators, occurred in this initial period that had somewhat impacted the differences in our findings, described in the previous chapters. Some of the differences between CONSENSO regions occurred partly due to app design, partly due to the fact that not enough time was devoted to the training for the evaluation and the usage of CONSENSO app, and partly because our interviewers were FNCs and not professional interviewers. Our recommendation for the future work is therefore to allow more time for the preparatory phase of the project; for the development of the indicators, development of the app, the model itself and also more comprehensive evaluation training.

Altogether 31 nurses were actively implementing CONSENSO activities. Until 20 June 2018, there were 4.878 clients participating in the project in all five regions (Carinthia, Liguria, Piedmont, Slovenia, Var) combined. Individual plans were designed for nearly 4.000 clients. Each nurse, on average, worked closely with 157 clients and performed 340 visits. The total number of visits by FCNs in all five regions combined was 10.526. In addition to the visits, the FCNs were available to clients by telephones, in their offices and through numerous events they organized (i. e. walking groups, local promotions, conferences etc.). Eight percent of the clients faced complex health problems which required more demanding treatment and numerous visits. In the beginning, the initial idea was to reach up to 500 clients per nurse, which soon proved to be too ambitious. Consequently, the consortium decided to lower the recommended number of clients per nurse in order to improve the quality of the field work. This decision meant that the CONSENSO model shifted more towards in-depth intervention, more towards a case management approach which demanded from the FCNs more proactive and support network building approach. This in fact led to the key result of the project which is the identification and treatment of the most vulnerable groups of the population with nearly 4.000 individual plans prepared and followed up, developed protocols for data management, counselling, coordination and other approaches that were tailor made for each participant.

The data described in this report indicate not only the immense efforts of the FCNs but also the differences between the regions (even between the two Italian regions where the model was implemented in a similar policy and socio-economic environment). For instance, the clients in Carinthia were the most materially underprivileged and the most socially excluded. They were on average the oldest, the least independent, had the worst health status, were facing the most as well as the most severe social and economic circumstances. Thus, the Austrian FCNs had to perform numerous client's visits (average 5 per client) in order to maintain their independence and prevent the institutionalisation. Clients in Slovenia, however, were (in comparison to other regions) younger, healthier, less dependent, more of them lived in more populated geographical areas. This reflects different approaches to selecting the target group, which was based on the partner's understanding

of the CONSENSO model and shaped according to either national or local priorities and needs. Sectoral priorities and the philosophies of the nurse as a profession in each participating region were also important factors in choosing different intervention approaches and activities predominantly pursued by FCNs. For example, in Var, where social care was highlighted and promoted especially by NGOs, the intervention did not focus on changing clients' risk prone behaviours and/or lifestyle. On one hand, this is evident in less prominent focus on exercise and healthy lifestyle promotion and, on the other hand, on more provision of support and empowering clients to remove whatever barriers they face. In the regions where the ideal of health prevention was more prominent, FCNs tried to encourage clients in changing their lifestyles, which meant less emphasis on the client's perspective as an integral part of the CONSENSO intervention model.

From the data that we collected, four different ideal types of FCNs can be identified:

- proactive FCN,
- preventive FCN,
- curative FCN and
- case manager.

Project partners in Slovenia saw the CONSENSO as an opportunity to provide more preventive health care (with focus on health education, promotion, measuring vital functions) to their clients and to highlight its importance. Austrian partners wanted to bridge the shortages in the system, which omits the most vulnerable population, and provided predominantly curative care. Partners in Var tried to enhance social care and case management in the area. Italian partners focused on proactive (instead of reactive) approach in nursing, i.e. taking control (anticipating autonomous role), anticipating and preventing problems as well as seizing opportunities. The project partners therefore discovered that regional introduction of a common ideal-type trans-national model of health and social intervention for the elderly was not an easy task. One could even argue that the project was not successful in this regard. Evaluation results namely show that each region adopted the proposed common model but also adapted it to better fit their own national and regional needs in this field, professional competences, existent policy environment and, most importantly, to the needs of the elderly the nurses worked with. These unintended consequences have, however, further enriched the project.

In spite of some methodological issues the evaluation process has faced, we can conclude that the project intervention was successful. It has delivered on its promise to improve the quality of life of the elderly and enable them to stay longer in their familiar environment if this is supported by the introduction of a key person being actively involved in seniors' lives, promoting healthy lifestyles and organising the support network when needed. The CONSENSO has succeeded in showing exactly that.

5. The social business model of CONSENSO

a. Main focus

The 'Social' Business Plan model has been created within the framework of the Co.N.S.E.N.So project [*founded by the Alpine Space Programme - ID-ASP286*] with the purpose of defining an easy-to-use tool for the same future 'social' entrepreneurs who become immediately the main experts and analysts of their own businesses.

As a matter of fact, the model comes to life by different training / consultancy experiences to business creation implemented by the authors themselves, having as main objective the dissemination of knowledge, and therefore awareness, for aspiring entrepreneurs with respect to the basic issues of doing business and operational management of their economic activities.

At the same time, however, this tool is fulfilling one of the basic functions of the Business Plan, which is the structured and analytical presentation of the business idea to third parties to which the nascent team caters for financial, economic and / or commercial purposes (*with a specific insight into the social dimension of the referred business sector*).

This model is thus centred on the exploration of the '***social dimension***' of the business itself, starting from the mapping and engagement of the relevant *stakeholders* and then clearly stating, structuring and measuring the real social targets and impacts of the company's action.[1]

Social entrepreneurship is the use of start-up companies and other entrepreneurs to develop, fund and implement solutions to social, cultural, or environmental issues. [2]

This concept may be applied to a variety of organizations with different sizes, aims, and beliefs. *For-profit* entrepreneurs typically measure performance using business metrics like *profit*, *revenues and increases in stock prices*, but ***social entrepreneurs*** are either non-profits or blend for-profit goals with generating a positive "***return to society***" and therefore must use different metrics. Social entrepreneurship typically attempts to further broad social, cultural, and environmental goals often associated with the *voluntary sector* in areas such as poverty alleviation, health care and community development.

The new vision of social entrepreneurship and social business in general has been somehow improved and reinforced leading to a new perspective of corporation acting for the welfare of the society. 'One of the models we've seen emerging in the past ten years is this idea of *social entrepreneurship*, which focuses on *people who primarily care about doing good*, not so much about making money. Social entrepreneurship and what it really does is very much in keeping with what we've seen so far, that it's about finding some stakeholders and creating value for them. And it doesn't matter whether it's for profit or not for profit.

i. Tools

In details, the **Model** consists of 3 separate tools which all contribute to the drafting of the final analytical document, namely:

- a **descriptive model** (*in Word format*) for the qualitative explanation of the entrepreneurial action,
- an **analytical model** (*in Excel format*) for the processing of the economic / financial investigation using all the information collected in the descriptive part, [3]
- **guides** / **studies** / **papers** (*in PDF*) to facilitate the understanding and therefore the use of the proposed tools.

The same choice of commonly used tools is dependent upon the desire to provide a simple model truly addressed to the same aspiring entrepreneurs, in order to facilitate the evaluation of

1 Purpose of this part of the analysis is to clearly state and measure (*even in economical terms*) the social impact of the company's services and then defining the proper strategy for the 'negotiation' with the public & private operators.

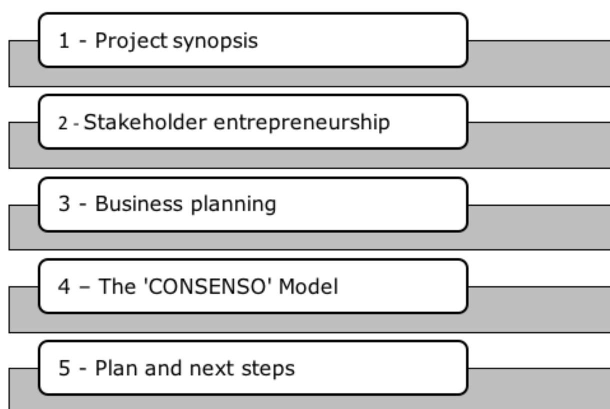
2 *Enterprising Ideas*, What is a Social Entrepreneur, PBS Foundation

3 All the charts & tables have been reported on the descriptive model to have a unique and complete tool for the Business analysis.

convenience and effectiveness of their business idea and thus support its "surfing" during the difficult first three years of activity.

The project CoNSENSo was intended to provide the target Family and Community Nurses [4] with the basic knowledge to acquire and then master basic contents on social business planning and management, addressing their operation to existing business players in the social sector or to cooperate with them.

In this sense first the FCNs have received a basic training on Social Business planning and management, tailored to regional peculiarities and needs, and then have been beneficiaries of tailored support to better test on the field the proposed Social Business Model to guide future social enterprise start-ups in the field.



After a joint transnational training seminar held in Klagenfurt on the 06.04.2017 which has been mainly addressed to the provision to the FCNs of a basic training on Social Business planning and management,[5] each regional responsible player has then deepened the knowledge with tailored regional training actions centred also to the specific regional and national peculiarities and regulations.

Despite of some remarkable differences especially on the regulatory framework governing the health sector,[6] both the common training framework [7] and the Model itself have been tested and validated in each partner region, contributing to the release of the final version as reported here in Annex.

6. Recommendations and suggestions for policies

a. Outline of Consenso partnership

CONSENSO has partners belonging to four countries which differ in social and health care systems, home care services and demographic scenario. Following a short description for each country is provided.

i. Italy: Piedmont and Liguria

Italy has a public medical service financed through general taxation. At the national level, the Ministry of Health (supported by several specialized agencies) sets the key principles of the National health system, determines the core benefit package of health services guaranteed across the

4 Co.N.S.E.N.So project aims at developing a care model that is built on the pivotal role of the Family and Community Nurse (FCN), playing an innovative role, becoming the key actor who shapes and manages personalised services for the elderly and their families, particularly those living in isolated areas. Each partner Region tests the FCN-based model of care in a selected area where all elderly (≥ 65 years), healthy or not, are assigned to a single FCN. Each FCN follows up to 500 hundred elderlies with periodical home visits.

5 In the image the reproduction of the main training contents.

6 Especially true in the case of *Provence-Alpes-Côte d'Azur* (FR) where the regulation is still limiting the exploitation of a private action in the sector - see the relevant paragraph for details.

7 See Deliverable 2.5.1 - Training contents and tools on Social Business planning & management

country, and allocates national funds to the regions. The organization and provision of healthcare is a regional responsibility. At the local level, geographically based Local Health Authorities (ASL - Aziende Sanitarie Locali) deliver community health services, public health and primary care directly, assuring the so-called *'essential benefit services'* defined by the Ministry of Health (LEA - livelli essenziali di assistenza). Primary care is provided by self-employed and independent physicians, general practitioners etc., paid according to capitation fee based on how many people they have on the list. Secondary and specialized care can be provided either by ASL's district hospitals or through public hospital trusts or by accredited private providers.

As far as home care is concerned, the Italian system is more or less cash oriented, through disability/invalidity pensions, and the majority of care is expected to be done by the family.

Italy is one of the countries where demographic changes are most prominent: people aged 85 or more will more than triple until 2050. The two CONSENSO regions seem to be affected significantly by the aging challenges; Liguria has the highest share of population 65+ in Italy (28,5 %), the share is also above average in Piemonte (25,0 %).

ii. Austria: Carinthia

The foundation of the health care system in Austria is a social insurance model that covers a majority of the population (99 %). Services are accessed according to law among which General Social Insurance Act is the most important. The Federal Government makes a legislative framework while the provinces (known as Länder) attempt to define legislation on enforcement and carry out the implementation (The Austrian Federal Ministry of Health 2010). Länder and local authorities take care of public health services and administration. Ensuring hospitals, health promotion and prevention services are done by the provinces while local governments take care of social welfare benefits and services (The Austrian Federal Ministry of Health 2010).

The description of health and social services in Austria is complicated due to its federal system. Organization, infrastructure, provision and even definition of services differ from one state to another. This includes institutional long-term facilities, home care and home nursing, and others. In Austria, home nursing and personal care are different services and are also reimbursed and regulated differently. Health care insurance covers home nursing (which is a health service) if the need is verified by the physician. Personal care and domestic aid are social services and are not covered by health insurance but by care benefits according to the federal law or one of the acts of each federal state. Families are seen as responsible for the care of their older members and around 80 % of all individuals get care and support by relatives at home.

The birth rate in Austria is generally low and the population is progressively aging. Austrians live longer but spend fewer of these extra years in good health compared to many of their EU peers.

iii. France: Provence-Alpes-Côte d'Azur

The provision of health care in France is under a national responsibility: the Ministry of Social Affairs, Health is responsible for defining national strategy. Health expenditures are funded by statutory health insurance. The ministry is represented in the regions by the regional health agencies, which are responsible for population health and health care, including prevention and care delivery, public health, and social care. The overall delivery of care is under responsibility of unique agencies at regional level (ARS), which work in close collaboration with the social services sector. Since 2001 for elderly there is an allowance, paid to dependent people over the age of 60, intended to cover the costs of any assistance they need due to the loss of their ability to care for themselves.

Home care for the elderly is provided mainly by self-employed physicians and nurses and, to a lesser extent, by community nursing services. Informal carers are called “natural helpers” so they are considered more as “co-workers” than clients whose needs and preferences should be acknowledged and answered.

In France, demographic state and trends are relatively stable, with lower old age dependency ratio (compared to other European countries).

iv. Slovenia: Obalno-kraška Regija

In Slovenia the system of health insurance is divided into compulsory health insurance, voluntary health insurance for additional coverage, and insurance for services that are not a constituent part of compulsory insurance. The health care system in Slovenia is under the responsibility of the state (The Ministry of Health). Primary health care services are organised locally, such that they are equally accessible to all people. Both public and private providers of care deliver primary health care. The social care system is under the responsibility of the state (The Ministry of Labour, Family, Social Affairs and Equal Opportunities) and municipalities. Social care services are, as mentioned, partly financed from state and municipal budgets, and partly paid by the users (recipients and their family).

In Slovenia governance on home care is split over two ministries. Home nursing falls under the Ministry of Health and is governed by the Law on Health Care Provision and Health Care Coverage, and Health Insurance Act. Personal care, domestic aid and social care, encompassing all other home care services, are the responsibility of the Ministry of Labour, Family and Social Affairs (MLFS) and are governed by the Social Security Act. Formal coordination is practically absent between different types of home care services. Home nursing (also preventive home visits) and technical aids are funded through a compulsory health insurance and through co-payments, in case of some technical aids. Basic costs of municipal health care centres are partially paid by municipalities.

Informal carers assigned as family assistants can be compensated for lost income, build up a pension and get a health insurance. Support services are partially funded by the government are counselling and advice for family carers and self-help support groups.

The need for care is already large, however it will only increase in the following years. Slovenia is one of the countries where demographic changes are most prominent and old age dependency ratio for 2050 is higher than EU-28 average (50,9).

j. Hints from Consenso project

Health service delivery is witnessing unprecedented changes in both medical and nursing science and in relation to the aging of population and to societal changes. Population aging is one of the greatest challenges in contemporary public health: one of the consequences of this dynamic is a greater demand for health services. Thus, it is important to carefully measure how well a society provides a context that facilitates successful aging:

- how to maintain independence and active life with aging?
- how to strengthen health prevention and promotion policies, especially those for the elderly?
- how to maintain and / or improve the quality of life with aging?

The aim of Consenso project is to raise the capacity of PAs and social sector to "re-invent" themselves and deliver innovation in services, in order to respond to these new challenges.

The principal innovation in health system is the introduction of the Family and Community Nurse (FCN), as suggested by the WHO-EU paper "Health for all in the 21st Century at the target 15: an Integrated health sector. The FCN is a health promoter and a case manager: its main goals are health promotion and primary and tertiary prevention, which requires a lot of health education to develop healthy living habits and improve understanding of the aging process. The community nurse role responds to social, political and economic perspectives together with changes in both global and national healthcare management. The professional roles and responsibilities of community nurses are influenced by government structures and changes, society and professional policies, procedures and guidelines. The Family Community Nurse would form the link between the different health and social worlds, facilitating a 3-way dialogue (Older people – Health services – Social services), fostering the personal engagement, organizing appropriate social services, like a home help or ready prepared meals, contacting doctors if a health problem is suspected and providing advice on how to adapt the home environment.

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In many Member States, a more integrated health sector is needed, with a much stronger emphasis on primary care. At the core should be a well-trained family health nurse, providing a broad range of lifestyle counseling, family support and home care services to a limited number of families. More specialized services should be provided by a family health physician who, together with the nurse, would interact with local community structures on local health problems. Freedom of choice in selecting the two should be the prerogative of individual citizens, and actively supporting self-care should be one of the tasks of the nurse/physician team. A community health policy and programme should ensure systematic involvement of local sectors and nongovernmental organizations in promoting more healthy lifestyles, a healthier environment and an efficient health and social service system at local level.

k. From Guidelines to Policies

Main goal of CoNSENSo was the improvement of elderly conditions in the pilot areas. This has been obtained thanks to the hard work of nurses. The Family and Community Nurses have proved to be a *best practice* both to improve the quality of life of older people in the remote Alpine Space areas and to improve health systems organization.

Furthermore, CoNSENSo projects set up a lot of datas: informations of health systems, legal framework for nurses, health indicators, prevented healthcare services. The dataset obtained is really significant and it can be used to address health policies.

Guidelines, overall, give general recommendations or advice for how to proceed in a situation; they are designed to streamline certain processes according to what the best practices are. Guidelines, by nature, should open to interpretation and do not need to be followed to the letter and should not be confused with formal policy statements. **The present output intends to be an instrument to help policy makers taking decisions to face aging of population and reorganizing health systems.**

Reports, data collections, outputs, experiences, case studies confirm that the FCN model experimented in Consenso project is a valid and successful experimentation. But in some cases CONSENSO has gone further. In Italy, for example, the testing is still going on financed through National funds. The Italian Inner Strategy, a national policy for remote areas, has taken the FCN

model as a best practice and it is strongly promoted in order to have further experimentations in other regions.

In some cases the CONSENSO model has already become policy. In Liguria FCN model is still ongoing in 16 municipalities of the Inner Area Valli dell'Antola e del Tigullio, and will start in other 3 remote area, including more than 20 municipalities.

Conclusions: aging is a challenge to be faced by Public Health and one of its main objectives should be to keep the elderly person in the community, with his family, in a dignified and comfortable way – **Home is a better place to grow old.** Thus, we believe in the importance of different forms of support, not only in terms of assistance, clinical treatment and rehabilitation, but also in the implementation of public policies and disease prevention actions, as well as health promotion of the population.

However, at present the model of care delivery in the primary care setting is commonly based on the role of the General Practitioner as the gate keeper of the care system. This could keep older people out of sight if they don't are aware of their condition and if they don't feel to bother the GP for minor problems, hindering the prevention of the decline or the intrinsic capacity and of the onset of the frailty in older adults.

The task sharing and task shifting is seen at present as the way forward the sustainability of care in the present demographic and epidemiological scenarios should start from this point a "well trained family health nurse at the core of primary care".