Needs of older population in health and social services

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Seventh meeting of the Academic Workshop conducted by the
Institute for Social Policy at the National Research University Higher School of Economics
Active Ageing Policy and Pension Reforms: Russian and International Experience

8 October 2019

A pilot research project conducted in **three Russian regions** with the support of the International Federation of Red Cross and Red Crescent Societies and the World Bank

Purpose and objectives of the research

- **Purpose**: to identify the extent to which a social policy aimed at providing health and social services to the older generation meets the needs and abilities of senior citizens in the Russian Federation based on a case study of selected Russian regions.

- **Objectives**:

1. to study the needs of older people in health and social services, and their satisfaction with the accessibility and quality of such services in different regions of the Russian Federation;
2. to study the current status of social and health services integration, and the barriers to strengthening the integration;
3. to draft proposals for the public authorities to increase the activity and potential of older people, and ensure the provision of relevant services and information awareness.

Why is it important?

The population of the Russian Federation is ageing, ambitious objectives are set forth to reduce the mortality rate

Active ageing

Development of health and social services as a government priority

National goals:

- Increasing life expectancy to 78 years (and to 80 years by 2030)
- Increasing healthy life expectancy to 67 years of age

National Demography Project

Older Generation Federal Project

Study methodology

Republic of Karelia

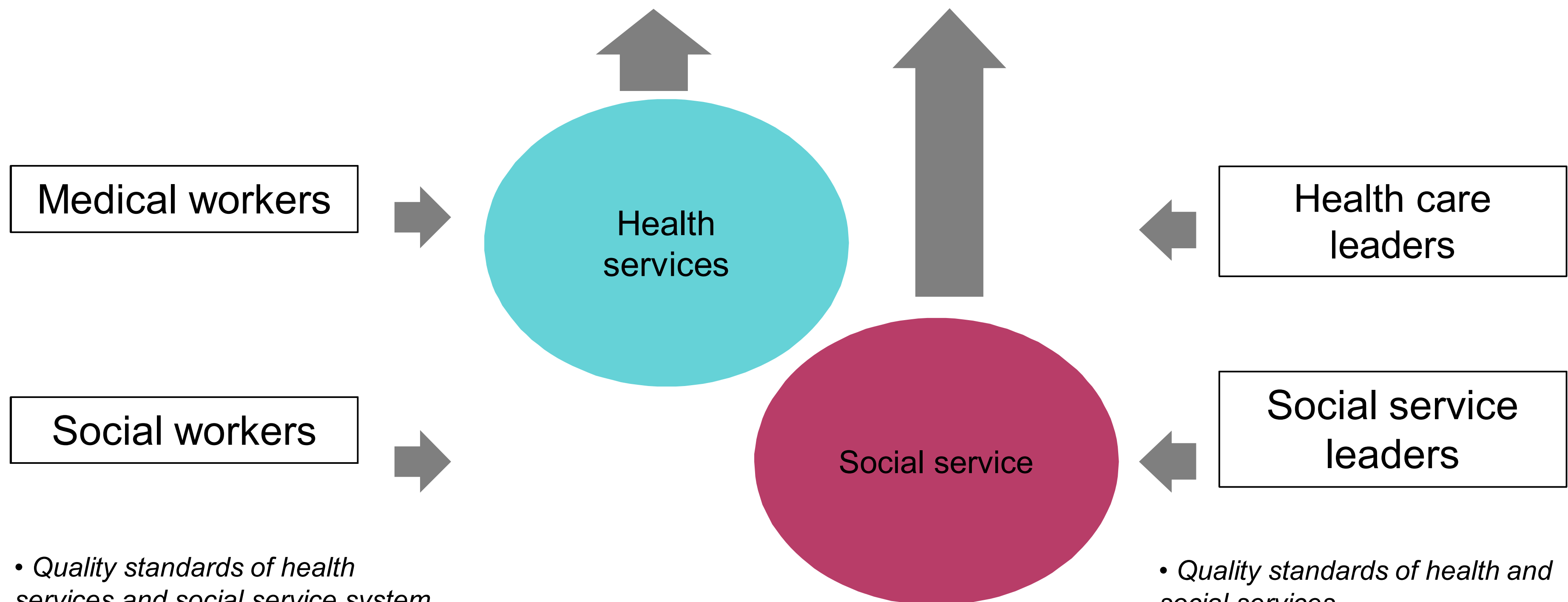
Oryol Oblast

Republic of North Ossetia – Alania

Field phase: April 2019

The functions of moderators and interviewers were performed by the workers of regional departments of the Russian Red Cross

Methodology for a qualitative study



• *Quality standards of health services and social service system*
• *Human resources for providing the services*
• *Professional ethics*

• *Quality standards of health and social services*
• *Resources of the health care system and social service system*
• *Maintaining the system's sustainability*

Methodology for a qualitative study

	Oryol Oblast	Republic of Karelia	Republic of Ossetia (Alania)	Total for the pilot regions
Total interviews,	21	24	21	66
Including:				
1. Interviews with older people				
older people aged under 65, men and women	3	2	3	8
older people aged 65 to 74, men and women	3	5	3	11
older people aged under 75+, men and women (or their relatives)	3	4	3	10
2. Interviews with the workers of organizations providing service to the elderly				
district doctors working at polyclinics	1	1	1	3
specialist doctors working at polyclinics	1	1	1	3
hospital doctors	1	1	1	3
medical nurses/paramedics (working in urban and rural areas)	2	3	2	7
social workers	1	1	1	3
3. Interviews with health care and social service leaders				
chief medical officers of polyclinics	1	1	1	3
chief medical officers of hospitals	1	1	1	3
leaders (deputy leaders) of the regional health care authority	1	1	1	3
leaders of social service centers	1	1	1	3
leaders (deputy leaders) of the regional social service authority	1	1	1	3
leaders of not-for-profit organizations/NGOs engaging in older people's problems	1	1	1	3

	Oryol Oblast	Republic of Karelia	Republic of Ossetia (Alania)	Total for the pilot regions
Total focus groups,	5	5	5	15
including				
focus groups with older people aged under 65 living in urban areas	1	1	1	3
focus groups with older people aged under 65 living in rural areas	1	1	1	3
focus groups with older people aged under 65 to 74 living in urban areas	1	1	1	3
focus groups with older people aged under 65 to 74 living in rural areas	1	1	1	3
focus groups with older people aged under 75 with permanent disability status	1	1	1	3

Analysis of the statistics and data from sampling surveys across Russia

Interviews
Focus groups

Outputs: a healthy lifestyle

A key driver to ensure healthy ageing is the right lifestyle and prevention of diseases

- In their health-seeking behavior older people rely primarily on their own efforts and (possibly, excessively) on **non-medical nature measures**: communication, high spirits, and raison d'etre.
- **A healthy lifestyle** has **NOT YET** turned into a common attribute of life **for all of the older people**.

“High spirits, a positive mindset. Think good thoughts. Yes, your thoughts will materialize. And even if you fall ill, you should not think it is your last hour, your last day.”

“But we have got accustomed that pills are the remedy for any trouble. Yet it is not true! What matters is repose, walks in the open, as well as your friends who do not complain about their sicknesses but charge you with optimism!”

“Thanks to our friends we kind of push it [the old age] aside, the best we can.”

“[I need] to see a friend, talk my soul out – to relieve me of everything [bad].”

Outputs: a healthy lifestyle

A key driver to ensure healthy ageing is the right lifestyle and prevention of diseases

- **Not all the** older people **know, which food is healthy**. Not all of them are sure that the foods they buy at their convenience store meet such requirements.

“I don’t know what kind of foods the shop offers, whether they are of good or bad quality.”

“Anyway, in summer we get healthy food from our vegetable garden: we do not buy fruits and vegetables, we eat our own produce, without any supplements. But, basically, when I go to a shop it’s difficult to say what I may buy there.”

“… when old people save money on food it aggravates their diseases because they buy cheap food, and we are conscious that food is made cheap through what? Through adding certain supplements that have the opposite effect: increase blood cholesterol, and glucose, sugar and so on.”

“We do not get any useful hints: how many calories I should get, should it be one apple or more. I wish I could know it. That would be good: I would buy half an apple, have one cookie, or tea. But I know nothing. So I eat anything that comes my way.”

Outputs: a healthy lifestyle

A key driver to ensure healthy ageing is the right lifestyle and prevention of diseases

- Senior-age adults support the initiatives aimed at providing them with active leisure opportunities. **And they prefer participation in group activities**.

"…I have three or four devices to stay healthy. But at home it is not always possible for me to use them, and here, for a team, I do physical exercises or hiking…»

"When you visit the center [for elderly people rehabilitation] – you feel dizzy, you can hardly walk. But once you mix up with people, you feel better. This kind of communication is vital for us!"

- Older people living **in rural areas** need **government's support to stay healthy**

"At all times, we ourselves are responsible for our health. More opportunities should be provided to pensioners to travel, have rest, and the pensions should be increased."

"Well, we need more health resorts at affordable prices, more free medicines. [In the past] the prices were lower, and free services were available."

- What can be done to improve the health of an elderly person?

- Above all, their financial and home conditions should be improved.

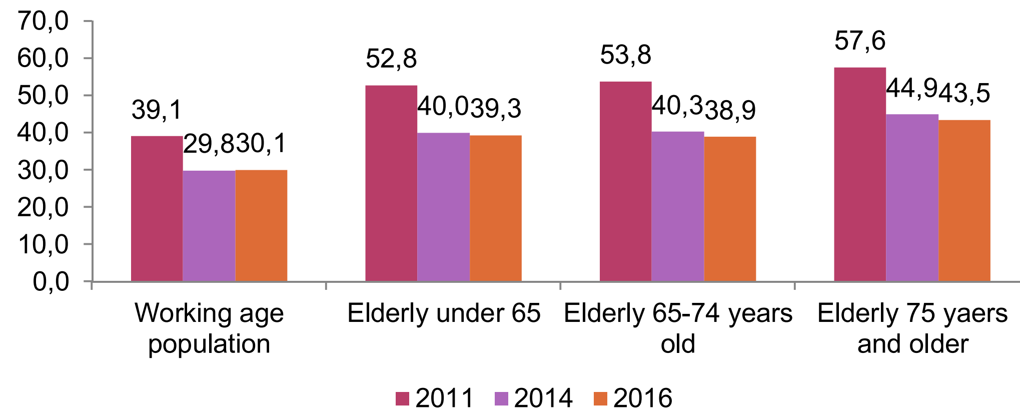
Recommendations:

A healthy lifestyle

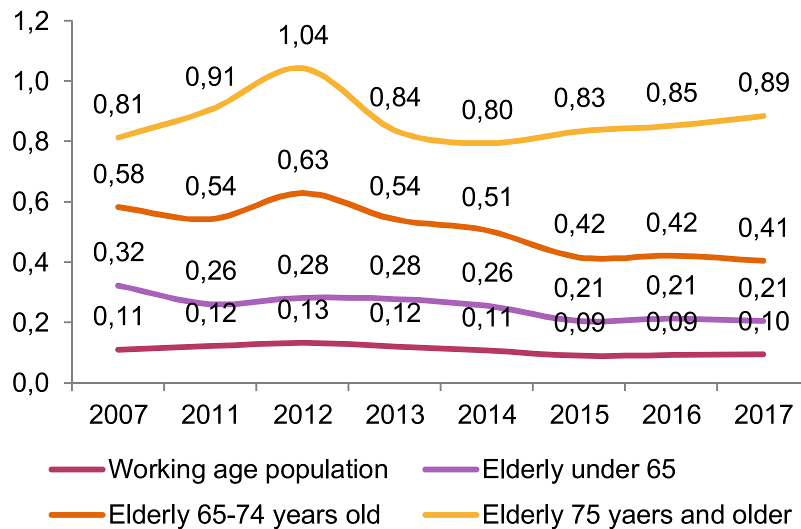
- Develop **special programs** to ensure healthy living for older **rural** adults, and **low-income** seniors (*prioritized access to health spas and resorts, invitations to free sports and entertainment events*).
- Ensure a focus on **group types of activities** at sports leagues and clubs for the elderly, develop volunteer movement.
- Use **silver volunteering** as a **tool to disseminate a healthy lifestyle** (peer-to-peer encouragement)
- Develop **healthy eating** programs for seniors jointly with **federal food chains** (**labeled** "Food for healthy eating in older age," **ensure the availability of information** on the permissible quantity of food being consumed, contraindications to certain diseases).
- Provide low-income seniors with **food stamps for healthy foods**.

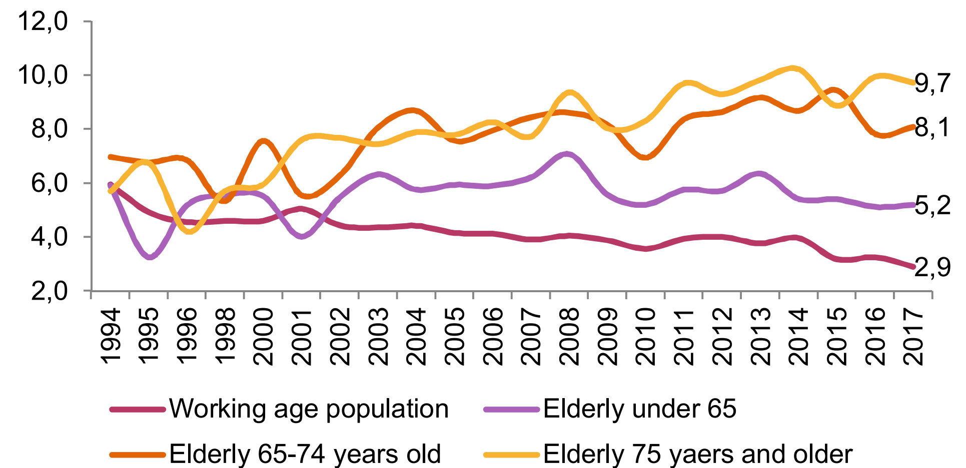
Outputs: health care

Accessibility of health care



Source: Integrated Monitoring of Living Conditions (Rosstat)





Source: RLMS-HSE

Outputs: health care

Accessibility of health care

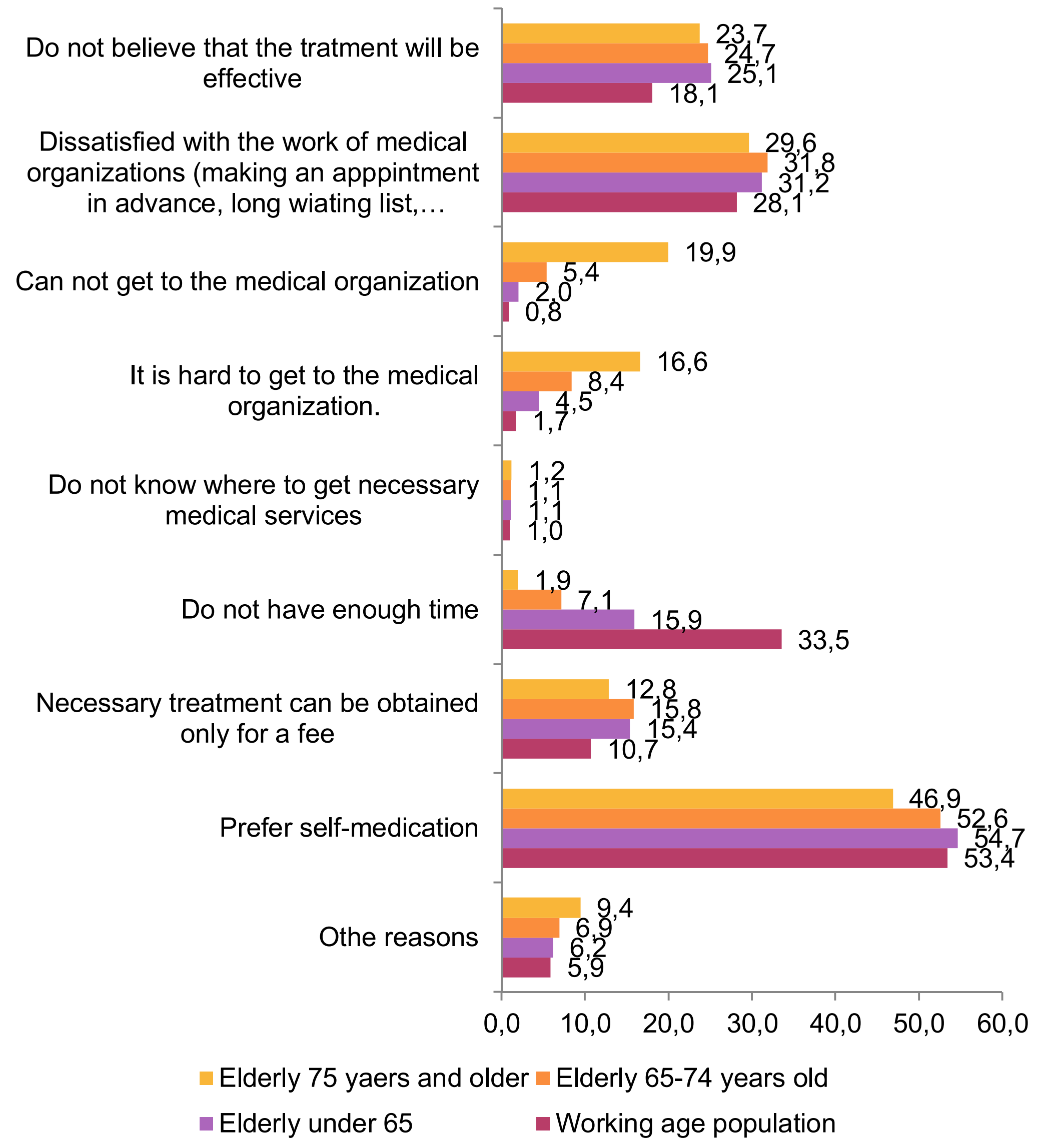
Chance of getting health care (treatment or examination) following physician's referral to health care providers of various levels in 2015-2016, %

	Among those with referral for treatment or examination			Among those who have been unable to undergo treatment or examination yet			
	Fully examined or treated	Partly examined or treated	Left unexamined or untreated	On the waiting list	The place to receive health care not determined yet	Paid treatment was suggested but is unaffordable	Other
Working-age population							
Referred to a territorial polyclinic /hospital	71,0	20,3	8,6	27,3	8,9	29,8	33,9
Referred to a specialist health care facility	68,1	22,5	9,4	31,3	10,0	30,6	28,1
Referred to a specialized health care center using high-tech treatment methods	54,6	28,5	16,9	30,8	6,3	34,2	28,6
Population over working age							
Referred to a territorial polyclinic /hospital	74,9	18,8	6,3	**40,8**	8,1	27,8	23,4
Referred to a specialist health care facility	64,3	24,2	11,5	**39,3**	9,3	30,6	20,7
Referred to a specialized health care center using high-tech treatment methods	58,2	26,9	14,8	**43,5**	7,3	29,9	19,2

Source: Integrated Monitoring of Living Conditions (Rosstat), 2016

Outputs: health care

Barriers to the accessibility of health care



Source: Integrated Monitoring of Living Conditions (Rosstat), 2016

Outputs: health care

Barriers to the accessibility of health care

- Non-availability of health care within easy reach
- Shortage of specialist doctors and diagnostics equipment at public health care facilities (in the opinion of both patients and doctors)
- Inadequate transportation networks, including those within the population center (not meeting patients' needs)
- ? Inertia of older age population
- Problems with obtaining documents required for access to health care
- Inaccessible environment (at inpatient centers)
- High costs of prescribed drugs

Outputs: health care

Telemedicine consultations as a way to increase the accessibility of health services for older age people

Rationale for implementing telemedicine services

- Long distances as a barrier to health care delivery
- Lack of older patients' awareness of their health status and treatment methods (including those undergoing chemotherapy in day-patient facilities)

"Or you go to a hospital, get your appointment letter, and wait there all day long to see the doctor… I wish there were a center with a doctor who I could get advice from about medicines."

- Availability of experience in obtaining telemedicine consultations

"… there was a case once when the ambulance refused to arrive so they [telemedicine doctors] steered me in the right direction, and we somehow found a solution to the situation."

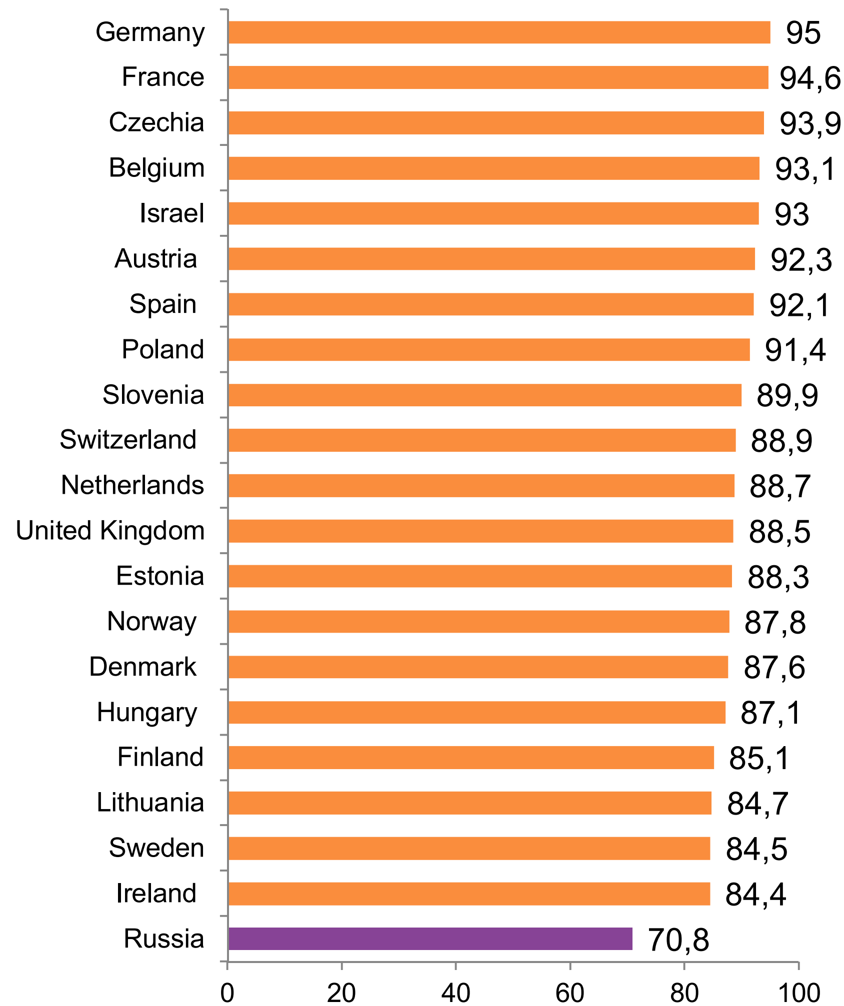
"You call the ambulance, describe your symptoms, and they prescribe you with medications."

- Adequate, according to the respondents, level of digital literacy of those who recently entered older age (computer literacy courses)

Outputs: health care

Telemedicine consultations as a way to increase the accessibility of health services for older age people

Share of Russia's population aged 60+ who discussed their health status with a doctor not more than 12 months prior to the survey, %



Source: European Social Survey (ESS), 2014

Outputs: health care

Accessibility of medicines

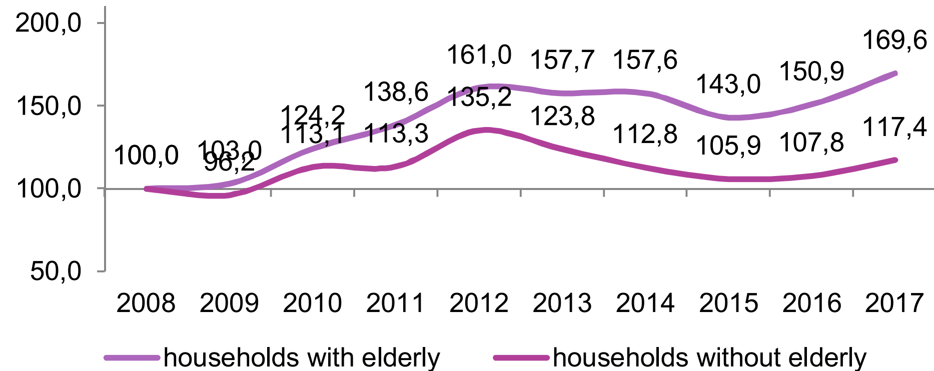
“And our idea is that we’d rather not eat but buy the medicines.”

“They don’t know: either they should buy something to eat, or buy some drug. And many people give up vitally important drugs, by the way.”

“What I mean is that I have to take 12 pills a day, but I have no permanent disability status so on the average I spend half my pension on medicines alone. It is only for diabetes that I get free drugs. The rest has to be bought, you see?”

“What does a pensioner spend his pension on? On foods and medicines. Just the cheapest drugs cost 500 roubles each, and our pension is 10,000 to 12,000 roubles.”

Growth of households’ per capita expenditures on medical treatment in real terms versus 2008, %



Source: RLMS-HSE

Percentage of older population entitled to free or discounted medicines, %

	Those entitled to free or discounted medicines	including		
		as part of the social services package	due to a chronic disease	for other reasons
Total population over working age	**18,8**	10,9	6,1	1,8
Older population without permanent disability status	**8,3**	1,8	4,6	1,8

Source: Monitoring of the quality and accessibility of public and municipal services (Rosstat), 2017.

Outputs: health care

Satisfaction with health care

- Solitude and need for interpersonal communication and psychological aid:
  - Besides reduced general condition and cognitive disorders, older patients typically have **increased vulnerability and need for psychological aid**.
  - Quite frequently it is the feeling of helplessness and frustration, rather than real health problems, that make them seek medical help.
  - An elderly person may apply for help to a "wrong address," which results in conflicts with medical workers and low satisfaction with the result of visiting a doctor.

"…many older people call for medical assistance not because they feel really unwell but because they have nobody to talk to. And so they may invent some kind of symptoms."

"They need care, attention, sometimes they come simply to talk, discuss a problem, i.e. it is not even a doctor that they need but a sort of socially trained worker, psychologist, or gerontologist…once you listen to them, help them, talk to them and have a chat, they already feel better, and their pressure is ok."

"Even if they have no aches, they want to be talked to, and to be paid more attention."

"Psychosomatics… [Older persons] take everything close to heart so all that affects their health."

A doctor, quoting his patients: "I haven't even taken any medication yet, I'll talk with you, and will already feel better."

Outputs: health care

Quality and accessibility of health services

- An increase in the number of ambulance calls and in the rate of hospital admissions among seniors aged 65+ points to **reduced accessibility of outpatient help provided to them**.
- **Types of health care less accessible to senior patients**: consultations of specialist doctors, diagnostic tests, medicines for outpatient treatment.
- Limited duration of doctor's consultation
- Polypragmasy (administration of 5 or more medicines at the same time)
- The inability to comply with the general practitioner's prescriptions results in **mass-scale refusals of senior adults to see doctors**. But those who overcome such problems, and are referred to higher levels of care, have a chance to receive treatment not inferior to that granted to working-age people.
- Geriatric assistance:
  - Older individuals have different attitudes to the introduction of geriatric assistance: from reserved scepticism to a pronounced positive response. More negative moods are found among the residents of the regions where basic health services are non-available.
  - **Medical workers** believe that they are quite well trained to treat older patients so they do not need any special courses in ageing-associated diseases. However, they often speak about **lack of knowledge about older patient's psychology**, which would help them build up a personal contact with such patients.

Recommendations:

Quality and accessibility of health services

For care delivery management

- Develop **before-doctor attendance**.
- **Split patients' flows** by age (under 75 years and over 75 years).
- **Increase the standard attendance time** for older patients aged 75+.
- Implement older patients' checkups by **multidisciplinary teams of medical workers,** with a **psychologist** included.

For increasing the accessibility of health services

- Develop **simplified formalization procedures for the treatment** (in hospitals, and using high-tech medical care) of older patients.
- Implement **telemedicine consultations** (doctor-patient contacts).
- Ensure an **accessible environment** at inpatient centers and polyclinics.
- **Provide for escorting older patients** with referrals to high-tech care centers, or other population centers.
- **Expand the subsidized drugs coverage** (at least, based on targeted aid)
- Provide for full or partial **refunds of private expenses on medical tests** whenever it proves impossible to undergo such tests at public health care facilities.
- Health insurance organizations should put forward **additional initiatives to protect the rights of senior-age patients**.

For improving health care quality and ensuring the system's responsiveness to the problems of the older population

- Develop a **communication strategy (set of recommendations for medical workers) for interacting with older generation patients**, taking into account the special psychological features of older people, their abilities and needs to receive information about their health and expected treatment outcomes.
- Include **expanded units on the psychology** of patients and older people, and practical units on communication with older people, **in the educational programs for training and retraining doctors and nursing staff.**
- Develop geriatric assistance as a potential **priority activity for the regions with adequate accessibility of other types of health care**.

Outputs: integration of health and social services

Currently used forms

Health care system – social service system

- Health promoting schools
- Provisions for preventive checkups of older population

Forms specific of the health care system

- Visiting care (by general practitioners, specialist doctors, and nursing staff)
- Emerging geriatricians' activities in the regions
- Discussions on patient's management strategy at hospitals and polyclinics
- Patient's attendance by a multidisciplinary team of doctors (Republic of Karelia)
- Building-up of collaboration with patient's relatives

Occasional contacts between the workers of the two systems

- doctor – to – social worker
  - – in case of deterioration of physical well-being of the service recipient;
  - – complications developed by bedridden patients
- social worker – to – doctor
  - – to ensure communication with the patient (e.g. finger language)
  - – assistance in complying with doctor's prescriptions

Outputs: integration of health and social services

Issues identified

Integration of health care and social service in providing services to older population:

- Attempts at establishing interdisciplinary and interdepartmental teams are being made by both ministries. However, it is **isolated or even one-time** activities.

Barriers to establishing interdepartmental collaboration:

- **The model** of interdepartmental collaboration has only been **brought to the notice of selected workers** of the health care and social service systems.
- **Shortage of geriatricians** and other **workers capable of coordinating** joint work
- **Shortage of health-care human resources** to be involved in the cooperation with social service organizations
- **Fragmentation** of the Russian **health care system**
- Incompleteness of integration processes: the **integration vectors** have been identified but not all of the related **organizational processes** are determined yet. The interaction is not reflected in the **tariffs**.

Recommendations:

Integration of health care and social service

- Include the **matters related to interdepartmental collaboration in the educational programs** for health care and social workers, and health care and social service policy-makers.
- Develop **geriatricians' training programs**, increase the number of attendees of training and retraining courses in this specialty area.
- **Update the standard for providing population with district doctors,** taking into account the currently developed programs aimed at delivering care to older patients with senile asthenia, and senior age people in need of long-term care.
- Introducing **supplements to health care delivery procedures** to ensure the intensification of integration processes.
- **Revise the health care and social service rates** to take into account the need for establishing multidisciplinary teams to provide services to the older population.

Conclusions

on the problems related to the quality and accessibility of health care to the older population

- The older population in Russia is facing the problem of health care accessibility. It is, above all, the inaccessibility of outpatient care. First contacts with the health care system are difficult to establish.
- The chronic accessibility problems result in refusals to apply to medical workers for help, and neglected, advanced cases.
- In general, it is typical of older patients to have low aspirations with respect to medical assistance quality. But certain patients (with psychological problems) attended to by doctors may have expectations that cannot be justified (they need a psychologist rather than a physician).
- Older people note lack of information about their health status, and the treatment they undergo. They do not have enough time to ask all of their questions during the time assigned for doctor’s consultation. And the arising problems cannot be *timely* resolved.
- Reduced accessibility of health care and instrumental attitude to health that older people tend to have, determine the lack of older persons’ interest in the practices of healthy lifestyle. Owing to the efforts of the health care system and mass media this information is disseminated among older population but there are still older people who do not care for a healthy lifestyle and are ignorant of its principles. The work should continue, and there is a potential for improvement.
- A lot can be done to improve the eating habits of the older generation: a proper older person’s diet, special foods (similarly to baby food), social support through providing wholesome food.

Outputs: position of older people in society

Fears associated with old age

- Old age = loss of interest in life, feebleness, and lameness
  - self-perception as a “used material,” when they can no longer produce anything (nor do meaningful work), and only have to consume, i.e. society does not need them anymore.

  “Once you retire you feel lame, nobody needs you, you are forgotten by everybody.”

  “People think they are old when they cannot maintain themselves but I’m not old.”

- Fears to be left in the dust – the key driver for living a healthy and active life
  - Abrupt deterioration of health is almost perceived as a disaster
  - **The strongest fear is that of growing feeble and needing continuous care**

  “If a person falls ill, God forbid, then it’s the worst thing that may happen. He then grows somewhat lame.”

  “... And when you fall ill after retiring, God help you, because all medical services are very expensive, And also, where can you find the time and the people to look after you?”

Outputs: position of older people in society

Fears associated with old age

- Another frightening aspect of old age is the disruption of traditional social links, and solitude
  - the ability and desire to keep in touch with those around you, and have a positive mindset are the foundation of a happy life, according to many people:

    "I also lack communication now that I'm retired. My children have grown up, and I'm left all alone in a closed space."

    " - Lots of people suffer from loneliness and isolation.

    - It's a generation not accustomed to going out for a walk, meeting with somebody, "come over, let's sit together".

    "Before I get to the [community] center, I feel dizzy, can hardly walk. But after mixing up with people I feel more at ease. This kind of communication is so important for us!"

    "[I need] to see a friend, talk my soul out - to relieve me of everything."

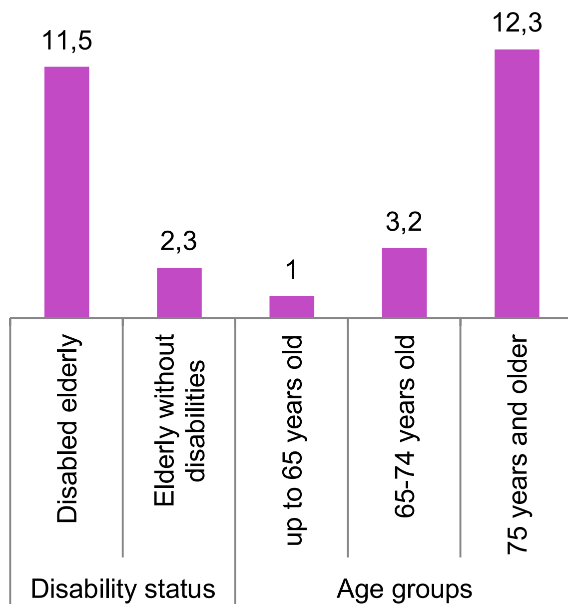
Recommendations:

Overcoming solitude and enjoying psychological well-being

- Provide older age **women with bonuses and discounts to use hairdressing and manicure services**.
- Focus on **group types of physical and leisure activities** for the seniors, develop voluntary movements.
- Increase the **accessibility of psychological aid to** older people.
- Introduce/add **psychologists' positions in the staffing tables of public health care centers**.
- **Raise awareness about the availability** of psychologist's consultations.
- Upgrade the transport and social infrastructure (free rides, new stops of public transport, affordable and regular transportation from the rural area to the region's population center)

Outputs: Social service

Coverage and accessibility



Monitoring of the quality and accessibility of public and municipal services, 2017

- When?
  - typically, people under 75 years of age are still capable of self-maintenance, and do not need others' help
- What kind of help?

  "From the others - exactly: fetch me some foods: heavy loads of potatoes, milk, and bottled mineral water – I drink a lot of water. And certainly cleaning."

- Whose help?
  - For everyday chores, preference is given to the family and relatives

    "Certainly, it's better when it is your near and dear, friends, the people you know, the warm ones. When a stranger comes to my place, he does everything in a wrong way, puts everything in a wrong place. It's better when it's your relatives."

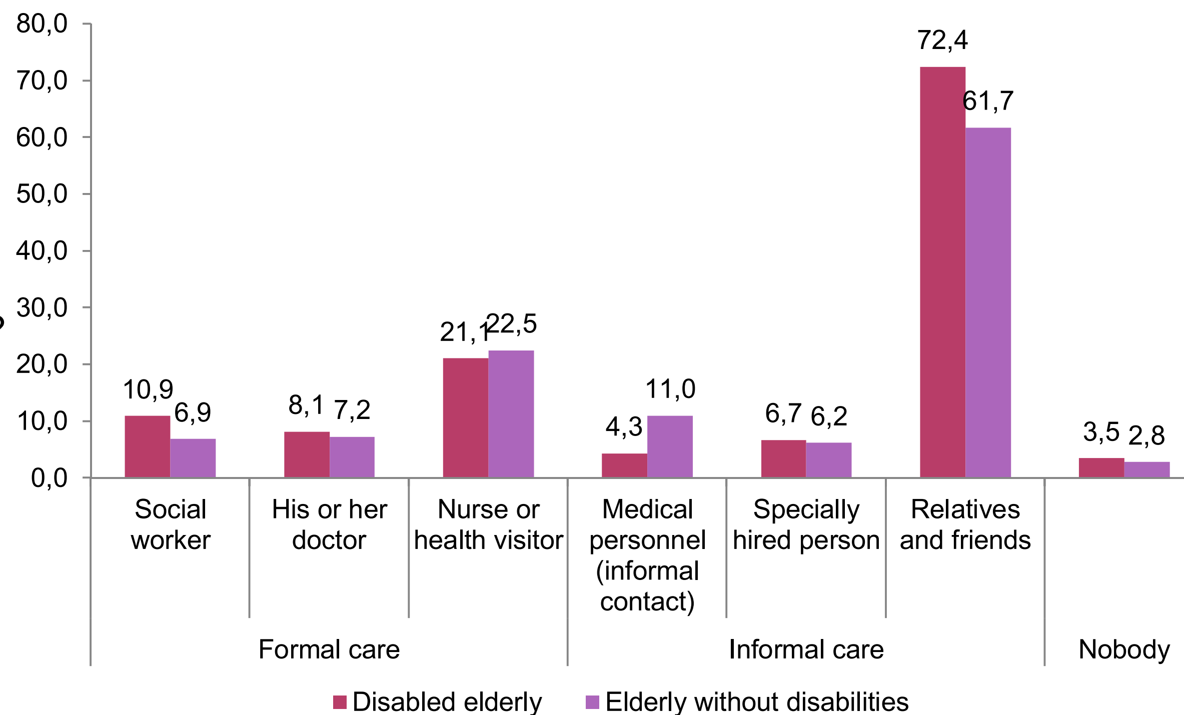
    "It seems to me that it should be your near and dear. No stranger can be better than a relative to help around the house."

    "If the person has children, it is primarily their responsibility."

  - Looking after a bedridden patient?!
- *"Who can do it better than a relative? I looked after my mother, and then after my brother for a month, but there would have been somebody to look after them."*
- *"It's difficult to look after sick people so it should be done by specially trained people, and they should be paid for it."*

Outputs: Social service

Accessibility, family or formal care?



Monitoring of the quality and accessibility of public and municipal services, 2017

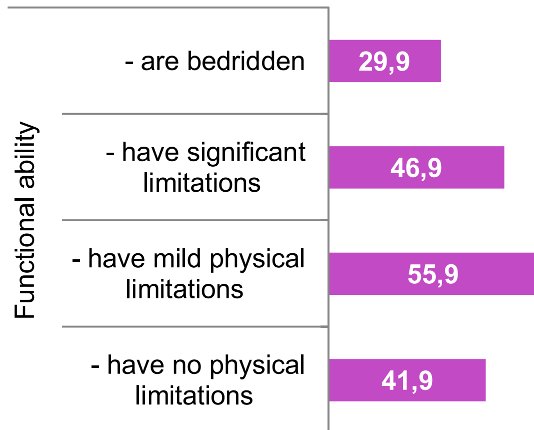
- Older people in Russia prefer getting help from their family and relatives. They believe that applying for help to social service institutions is undesirable. The prospects of developing family care are evident.
  - The risk group is solitary elderly in need of permanent care

  “I‘d say that some people do need it because a social worker … has time limits. He is limited by time. He cannot stay with the patient round the clock like family and relatives do. A solitary person is unable to move around the flat. And we certainly suggest that such people should go to a residential care home. But for some reason they refuse.”

- Social workers – if there are no relatives / or relatives live far away or have to go to work
  - *“Not everybody has relatives. Hence a social worker is needed, but it should be a well-trained worker, and, certainly, not from a not-for-profit organization.”*
  - *“I believe it should be a social worker. Relatives have to work, they have their own problems.”*
- Only half the elderly in need of social service get it from social service organizations.

Results: Social service

Accessibility and barriers



- The population and health care workers point to lack of supply of social services of all types, and primarily nursing services. Social service leaders recognize only a shortage of vacant beds in inpatient service facilities.

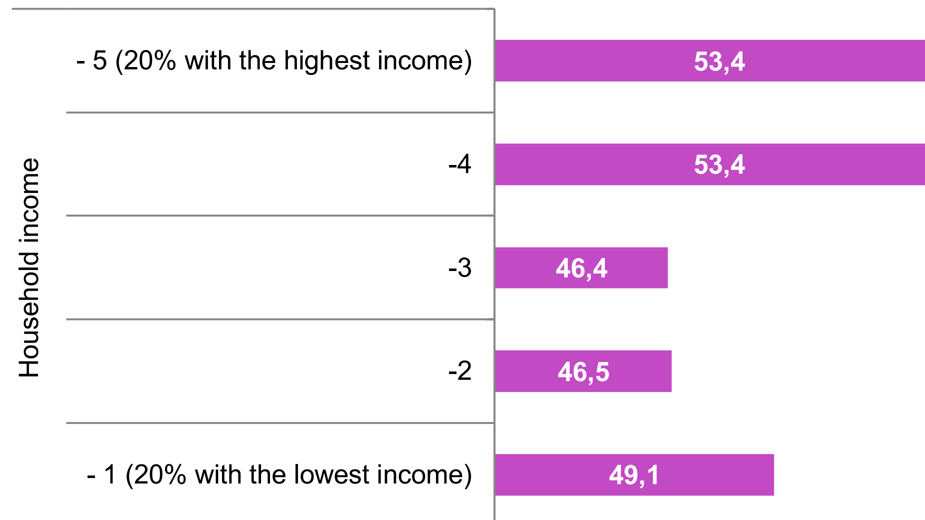
  "Social workers should not look after all those who are bedridden. That should be done for an extra fee."

  "… some severely ill patients need care round the clock. But we do not have an inpatient service. And sick attendants — their services are to be paid for, and some people can't afford it. The pensions are too small."

  Well, I think by about 40%, very roughly. They are human. The demand is high but satisfaction is probably by about 40%.

  "Who is denied service? Tell me who? Well, possibly those who are mentally unstable, we do not accept such patients. And we do not accept patients in need of permanent care. We can provide service if there is an attending nurse, but the social worker is to perform his own functions."

- Barriers to obtaining social service:
  - ✓ Time-consuming paperwork necessary to obtain the service
  - ✓ Need to pay a fee
  - ✓ Lack of population's awareness about the existence of social service centers
  - ✓ Inconvenient location of social service institutions



Monitoring of the quality and accessibility of public and municipal services, *2017*

Results: Social service

Confidence in service providers, willingness to pay a fee

- The population trusts mostly to the workers of public social service institutions.

  "the person's responsibility and training," "the [social protection] institution is protected by the government, and has a higher credibility," "if something should happen, it's possible to file a complaint with the social protection institution."

- Volunteers and workers of not-for-profit organizations and business entities are deemed less credible service providers.

  "… And volunteers, well, volunteers are usually young people, She comes today, and tomorrow she doesn't… Volunteers are unreliable young people."

  "And if we apply to a business entity, well, we'll be short of money to pay for their help…"

  "Social protection workers. You will be protected by the government and the law. But all business entities will evade the law. They will hire a lawyer and claim that your contract is not duly executed."

- People, even those who have reached the age when care may be needed, are not willing to pay a care tax. The elderly believe that social service should be free of charge.

  "A portion should be paid for by the pensioner, and a portion – by the government."

  "The wages are low. Social protection services should be paid for by the government. We have worked and paid the taxes. Our children also pay taxes, and they should not pay for the care provided to their relatives."

  "In the past, when we worked, we paid taxes, and they went to health care and social services. Why should we pay another tax?"

  "I believe we already pay taxes that go health insurance, we pay, we work… So what's the point of imposing one more tax? To have it frozen tomorrow, with the money gone somewhere that nobody knows where..."

  "It should be paid by those whose wages are high enough. This tax should be purely voluntary."

Recommendations:

Social service

- **Should services be provided only to those who apply for them, or also to those identified by social workers as being in need of services?**
  - The "identification-based" principle implies an additional load on the system; the "application-based" principle implies a gap in the coverage
  - A mixed scheme is possible: the "identification-based" principle should apply to senior-age people **(aged 75+ or 80+) and solitary old people**
    - the people in need of social service should be identified based on their health profile and functional limitations
  - **ensure that the people who have practically no contacts with social services are included in the social service system**.
- It is necessary **to develop hospital-replacing technologies** enabling low-mobility older people to stay in their familiar home environment without hospitalization, and follow their usual mode of life.
- Inter alia, it is necessary to **ensure the availability of the services of professional attending nurses** who are skilled enough to ensure quality care to such people.
- **Development of uniform standards and mechanisms to monitor the performance of public and non-public providers** of social services, including permanent care by another person.

Recommendations:

Social service – family care and management

- Given the fact that family care still remains one of the most sought-after and socially acceptable forms of care of the elderly, measures should be taken to ensure **adequate financial compensations to the relatives attending to the elderly**.
- The study has shown that currently it proves impossible for relatives looking after a bedridden senior person to have him/her admitted to a hospital in order to get a brief respite. To **prevent a professional burnout** the problem should be addressed using government policy tools. ➔ **Substitutive care**
- It is necessary to **organize short-term courses to provide training in the necessary care skills**.
- To improve the quality of life for the older population and relatives looking after older persons unfit for work, **psychological and social support should be provided to both low-mobility elderly (particularly, solitary seniors) and the relatives** looking after them. That will possible require **adding psychologists' positions in the staffing tables of health care and social institutions**.

Conclusions

on the problems related to the quality and accessibility of social services for older population

- The problem does not only consist in low pensions. To some extent, low subjective well-being is due to solitude and low accessibility / inadequate quality of health care and social aid
  - Group types of leisure and sports activities
  - Psychological aid
- One of the biggest fears is losing the ability to self-maintenance, and the fear of getting bedridden
- The risk group is solitary old people aged 75+
- Family care – voluntary and involuntary
- Professionalization of family care (increased payment, training, supportive care, substitutive care) as a way to expand the service coverage without overloading the long-term care service
  - Uniform standards and tools to monitor the performance of public and non-public service providers as a solution to the low credibility issue.