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Introduction

How to cope with ageing societies is one of the grand challenges pointed out in the Lund Declaration[1]. The rapidly growing population of seniors[2] confronts Europe with a double demographic challenge. An ageing population's need for healthcare services increases at the same time as the access to workforce declines[3].

Use of technology can be increasingly important for the society to be able to offer health care services at a quantity and quality that mirrors the expectations of the European populations. Our society can choose different strategies for the care services, and for the introduction of new technological tools in this sector. The technology promises many opportunities, but there are challenges to be solved and ethical dilemmas to be considered. How can we best use new technology in care services, what is acceptable and what is the resistance by the seniors themselves, and what type of options are policy makers faced with?

Scenarios

To create awareness of the possible consequences of political choices, the PACITA-project have, together with a European stakeholder group, developed three scenarios; "One size fits all", "Freedom of choice" and "Volunteering community". They differ with respect to which degree public and private players are providing future seniors care and how the seniors and other groups in the society organise themselves in order to meet the needs for care. To create awareness of the possible consequences of the choices, the project have also developed user stories, where four people are pictured and further described how they could live their lives in 2025 in the given scenarios.[4]

Scenario Workshop

To facilitate and provoke forward-looking discussions and identify policy alternatives the PACITA-project have conducted ten national and regional scenario workshops in; Denmark, Czech Republic, Hungary, Ireland, Catalonia (Spain), Norway, Wallonia (Belgium), Switzerland, Austria and Bulgaria. A scenario workshop is a method aimed at facilitating forward-looking discussions and identifying policy alternatives in different contexts. In PACITA, the workshops aims to stimulate discussions on how one can meet the needs and face the challenges of the rising number of older adults in different European countries, with a set of scenarios as a starting point for the discussion.

The scenarios and user stories have been used to provoke discussions in scenario workshops on how one can meet the needs and face the challenges of the rising number of older adults in the European countries. The scenario workshops in the PACITA project have produced visions for what kind of seniors care services the Europeans (though the views of a diverse range of seniors care stakeholders) want and policies envisaged to achieve these visions.

This report summarises and analyses the results of the national scenario workshop held in Prague, the Czech Republic April 29, 2014.

The findings from the ten national workshops will be gathered and analysed in a synthesis report, to be presented to regional, national and European policy-makers at a policy conference in Brussels in late 2014.

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[1] [Lund 2009]

[2] The term 'elderly' is commonly used. We are aware that this is a sensitive terminology. We have chosen to use the more neutral term 'seniors' throughout this document.

[3] An ageing population is defined as a population in which the number of elderly (65+) is increasing relative to the number of 20-64 year olds. http://www.population-europe.eu/Library/Glossary.aspx

[4] Reference to the scenario document#

National Context

The current demographic structure is characterized by two large baby-boom cohorts, post-WWII and mid-1970s, when natural fertility was supported with strong pro-natalist policies and the general circumstances of the socialist political system.[5] These significant fluctuations in the demographic structure had a crucial impact on the social conditions of the country, including on the labour market. It is expected that the Czech population will age in "leaps" and its ageing will culminate around 2050 when the group of seniors will incorporate the parents of the post-cold-war baby-boom generation as well as their numerous children.

As a result of the demographic situation described above, combined with dynamic socio-economic developments after the so called Velvet Revolution in 1989, the Czech society is characterized by generational differences. Today's seniors have lived most of their economically-active life under socialism with a centrally planned economy, which was rigid in some aspects but, at the same time, provided individuals with some certainties and securities. The significant part of today's Czech managers are recruited mainly from the generation of so called "children of *Husák*" (named after the then president), i.e. they are between 35-40 years old, are very active and independent, travel widely, speak foreign languages and are much more self-confident than the previous generations. This is the generation that decides largely about business and politics now.[6] To a certain point, this huge difference of personal experience causes a social gap with no satisfactory inter-generational solidarity.

Today, concerning the general demographic trends, we see that the people in the Czech Republic live longer than previous generations, which is a result of an increased life expectancy. In 1960s, the average life expectancy was 67.5 years for males and 73.3 years for females. As for now, it stands for 75.0 years for males and 81.1 years for females.[7] In terms of basic age components of society, a future prognosis says that a share of seniors will get significantly larger than a share of economically active population. The biggest growth will be seen in the group of 85+ seniors. For example, a prediction for 2075 says that there will be 3 million seniors in the Czech Republic – compared to today's 1.7 million. On top of that, an economic burden of pension, social and healthcare systems has been already increasing significantly – in comparison with the other EU member states, even a quicker dynamics of population ageing can be expected (Eurostat: 15.2 % of 65+ seniors today, compared to 30.7 % in 2060).

In accordance with the European trends, senior households are becoming more and more important to the national economy as one third of the private households are inhabited by seniors.[8] Therefore, some crucial questions arise such as, for example, how to prevent frailty and fall incidents of senior citizens and support their active life at home. This tendency will be further strengthened given the

[5] Možný, 1999; Rychtaříková, 2000

[6] CASE Network Studies and Analyses No. 469 – Conceptual Framework of the Active Ageing Policies in Employment in the Czech Republic.

[7] World Health Organisation, 2011

[8] Czech Statistical Office, 2013

low ratio of retirement homes to number of senior citizens.[9] In these circumstances, working from home could become a viable option as it has been more and more popular among the employers and employees, too.[10] Telecare and telemedicine could as well greatly influence the overall economy of the Czech Republic and support adequate and safer conditions for still employed senior citizens.

Definitions

In legislative intentions of the eHealth Projects (version 1.7), the Ministry of Health uses the following terminology:

eHealth: *electronic health care, is defined as the application of information and communication technologies across the whole range of processes and functionalities, affecting quality and efficiency and accessibility of health care. eHealth includes tools and solutions, including products, systems and services that are beyond the standard internet applications. eHealth is essentially a tool for health management, medical devices, and health care experts of different kind as well as for public and personalized health information systems for patients and citizens and health insurance payers.*

Telemedicine: *Telemedicine is a pioneering activity of computerization of health care, which has been ongoing for many years. It is based on the principle of sharing medical knowledge for diagnostic, therapeutic and educational purposes. Practically, it is based on on-line and off-line network transport of medical data including tele-consultation and tele-navigation based videoconference transmissions point-to-point or point-to-multipoint.*

Assistive technology: *Assistive Technology in Healthcare targets ageing population and impaired persons, which are profiting from the recent technology enabling them a better and safer life in home environment, fostering rehabilitation, monitoring after operation treatment. Possibility of re-inclusion back into professional life so as improvement of home and social care tends directly towards increased economic efficiency.*

[9] Ministry of Labour and Social Affairs, 2008

[10] Institute of Sociology ASCR, 2008

Local Players and Responsibilities in the Care Sector

Table 1 below shows all the different agencies involved in the policy-making at a national level – **national policy enablers**. The actors include, but are not restricted to, government departments, other statutory agencies and voluntary and private sectors.

Name of Agency	Type of Organisation	Description of Role	Impact
Ministry of Health of the Czech Republic	Government Agency	Responsible for policy in relation to the Czech health services.	Recently initiated the adoption of the Legislative intentions of the eHealth projects + in October 2012 launched a public tender on "Efficient and operational e-health": New electronic system, which allows physicians, health insurance companies and patients to share information about treatment (estimated cost of 20M EUR).
Ministry of Labour and Social Affairs of the Czech Republic	Government Agency	Responsible for policy in relation to the Czech social services.	Settled the National Action Plan Supporting Active Ageing for 2013 – 2017 + founded the *Government Council for Ageing* – Work Group for Age Management and *Prize for the Application of Age Management*.
Czech Medical Association of J.E. Purkyně: Czech Society of Medical Informatics and Scientific Information	Voluntary independent association of experts – physicians, pharmacists and other personnel in healthcare and affiliated fields - or legal entities	The basic organisational units of CzMA are professional societies formed on professional (expert) basis and fellowships of physicians formed on the territorial principle.	CzMA sees to development and spread of scientific information of medical sciences and affiliated fields, pursues utilization of this information in public healthcare with a special emphasis on preventive activities.
Czech National Forum for eHealth	Non-governmental non-profit organization, civic association	Goal of this forum is to focus on expanding and rising awareness of eHealth, support of development of eHealth and support of communication in the field of eHealth.	Members of CNFeH and other experts nominated by the Forum participates on activities of working groups of the Joint coordination committee on eHealth and help to build a conception of development of eHealth in the Czech Republic.
MEDTEL, o.p.s.	Non-governmental non-profit EHTEL-like organization (European Health Telematics Association)	Open platform for all kind of participants active in the field of medical informatics and telematics.	Permanent democratic and neutral forum where the different categories of actors (authorities in health care, health care providers, health insurers, patient associations, citizens, interest groups, companies operating in the field of Health) to meet and formulate strategies.

Table 1: The list of the national policy enablers in the Czech Republic and their impact based on e.g. national incentives put in place to encourage the adoption of telecare and home-based-telemedicine practices.

Table 2 below summarises the target groups who are recognised as the **enactors of the policy**. For example, organisations and communities that represent the interests of people who use health and social care services are deemed to be policy enactors. Furthermore, clients, family carers and care providers are part of the care system enacting policy. Finally, policy enactors refer to members of the public and communities who are potential users of health services and interventions.

Name of Stakeholder	Type of Stakeholder	Source of reference	Description
Czech Association of Patients	Civic association	International Alliance of Patients' Organizations	CAP is involved in the preparation of laws, decrees and regulations in cooperation with the Ministry of Health; promotes patient representation in the supervisory boards of medical facilities and health insurance companies, and keeps a free counselling centre for patients
Association of Diabetic Patients of the Czech Republic	Civic association	Ministry of Health of the Czech Republic	The mission of the ADP is to assist diabetics in the Czech Republic in their full integration into social life with health, social and other activation programs and to participate in educating the public about diabetes.
Czech Alzheimer Society	Civic association	Alzheimer Europe and Alzheimer's Disease International	CAS is based on encounters and cooperation in the field of gerontology experts (doctors, nurses, social workers, social work students and others) who have dealt with the issue of people with dementia. Among its members, there are as well family members and care providers.
Parkinson Society	Civic association	European Parkinson's Disease Association	Members of the PS meet in clubs operating in the major Czech cities. These regional clubs organize a large number of events for Parkinson's patients.
Government Council for Older Persons and Population Ageing	Permanent advisory body to the Czech Government on issues related to ageing and older persons.	Government Office	Confederation of organizations that are trying to help senior citizens.

Table 2: The list of the national policy enactors in the Czech Republic

National Policies

How to respond to the double demographic challenge? One way is to support active and healthy ageing and the other is to support natality (and migration) with the aim to ease the dynamics of demographic ageing and to ensure the financial sustainability.[11]

This section outlines policies specifically related to the ageing society, e-Health, telecare and home-based telemedicine. The following list includes policy measures as well as programmes related to the agenda of ageing society.

National Action Plan Supporting Positive Ageing 2013-2017 (NAPSPA)

In February 2013, the Czech Government approved the National Action Plan Supporting Positive Ageing 2013-2017 (NAPSPA) including, among others, the following areas: lifelong learning, employment of older workers in relation to the pension system, volunteering and inter-generational co-operation, and healthy ageing. This Plan is the third one in this area the government has approved so far (I: 2003-2007; II: 2008-2012). The advantage of the third plan – in comparison with the previous ones - is that it shall contain also the monitoring indicators measuring the implementation success as an annex.

The general goals, defined by the NAPSPA, are:

- Revision of the pension system to increase motivation for longer employment of pre-retirees
- Support for self-employment of the unemployed
- Implementation of age-management strategies on different levels
- Support for occupational medicine

The measures include:

  - Analysis and adjustment of the pension system in terms of timing and available pathways
  - Review of the continuous employment on pension benefits effects;
  - Increase of the information level on pension system and enhancement of the provided information services quality
  - Support for self-employment of the senior workers
  - Support for institutions providing further education to include up skilling for older workers;
  - Identification, collection and advertisement of good practices in flexible approches to older workers and older people employment
  - Training and education of managers and officers at employment offices working with older clients to create an age-friendly atmosphere etc.

The NAPSPA was prepared during the European Year of Active Ageing and Inter-generational Solidarity (2012).

[11] Kocourková, J.: Demografické stárnutí české populace v evropském kontextu. Presentation on the Prague seminar on 29/4/2014.

Biennial Collaborative Agreement between the Ministry of Health of the CR and the Regional Office for Europe of the World Health Organization for years 2012-2013

In 2012, the Ministry of Health of the Czech Republic signed a collaborative agreement with WHO for 2012-2013.[12] The Priority 5 of this agreement is devoted to Health Information, Evidence, Research and Innovation. Enhanced analytical products for planning, monitoring and evaluation of health situation and inequalities in support of decision making and reform processes responding to the health needs are planned to be introduced.

Research and development programme of the Ministry of Health III. for the years 2010 – 2015

In 2009, the Ministry of Health has introduced a research and development programme for 2010-2015. The basic aim of the RDP III is to fulfil the obligations of the Act No. 211/2009 Sb. to implement the reform of research, development and innovation policies in the healthcare, and to increase efficiency of the use of public funds in the health research. There is a need for practically applicable results of the research for diagnosis, treatment and prevention of diseases, healthcare systems, development of informatics and nursing, and ultimately for securing international level of comparable research results.

Legislative intentions of the eHealth projects (Version 1.7), the Ministry of Health of the Czech Republic, 2008

These legislative intentions are one of the tools for the creation, on-going updates and gradual implementation of the concept of development of eHealth in the Czech Republic. Key areas are national policies and programs, electronic health record, efficient, safe and reliable health information and communications network, electronic identification of patients and medical staff, health care payment system, e-learning and inter-connection information for acquiring new knowledge to improve the health status of the population.

Age Management project implementation in the Czech Republic

In 2012, also the ”Age Management” project was conducted by higher education partners and the regional branches of Employment Offices. The project was based on a strong foreign partner who developped the tool and tested it in Finland and in other EU and non-EU countries. Findings of the project were used by the Ministry of Labour and Social Affairs (MoLSA) and resulted namely in foundation of the Government Council for Ageing – Work Group for Age Management and Prize for the Application of Age Management. Currently, there are two follow-up projects being implemented with the aim to put recommendations of the NAPSPA into action and support the age management principles in the private as well as public spheres. Also, a monthly journal called Age Management was launched in 2012 by PR agency ANTECOM as a response to difficulties in finding free media coverage of the topic.

[12] Conference MEDTEL: Telematics in Health, 2013

Technological Status and Development

This section outlines the type and nature of support programs available to support the adoption of telecare and home-based telemedicine policy. Inclusion of the date will help determine the maturity of services available. Furthermore, the type of service provider will provide insight into the mix of private and public services on offer.

Name of Service Provider	Objective	Type of Service Provider
Institute of Health Information and Statistics of the Czech Republic	Interactive atlas of health inequalities	Government Agency
Czech Technical University in Prague, Faculty of Electrical Engineering, Department of Telecommunications Engineering, Department of Cybernetics	Research on the assistive technology devices for disabled people and on the home based telemedicine – model apartment with sensors	University
Czech Technical University in Prague, Faculty of Biomedical Engineering (Kladno)	Research on the medical simulation (traumatic brain injury, ambulation and balance disorders, etc.)	University
Charles University in Prague, 1st Faculty of Medicine, Medical Data Centre	On-line monitoring and economic aspects of eHealth	University
Charles University in Prague, 2nd Faculty of Medicine, Motol Hospital	Research on the assistive technology devices for disabled people	University
Brno University of Technology, Faculty of Information Technology	Research on the information technologies for telemedicine	University
National Medical Library	On-line health care and medical data availability	Library

This section outlines the current types of telecare and home based telemedicine technologies that are currently in use or on the market. The information provided here will determine the take up and distribution of telecare. In addition future planned technologies, which are in discussion on the national scene, are of interest here.

Type of Telecare/ Home-based Telemedicine	Currently in use	Future Planned	Description
Assistive technology devices for people with hearing disorder	x		Assistive technology devices for people with hearing disorder (Doc. Z. Kabelka, CU-2FM)
Navigation system for visually impaired people	x		Using three satellites at any given time to precisely navigate blind people from point A to point B – included public transport instructions (Doc. J. Chod, CTU)
Electronic medical files	x		DASTA 3 encrypted electronic medical files for communication between physicians, insurance companies and patients (Dr. J. Vejvalka, CU-2FM)
On-line monitoring gadgets for overweight people	x		Remotely monitoring weight changes, metabolic parameters and fatty tissue (Doc. L. Streda, CU-1FM)
Model apartment with sensors		x	Model apartment with sensors in all rooms to secure permanent non-invasive monitoring of the patients (CTU)
Wheelchair-friendly apartment		x	Apartment for people with severe motor disability – included wheelchair friendly kitchen and bathroom (CTU)
Device for finger pressure measurement		x	Non-invasive device for finger pressure measurement – included other blood tests (CTU)

Stakeholder Workshop in the Czech Republic

Preparations

Participants: All participants received the Scenario Document after they registered to the workshop. It was expected that everyone had read this document before the workshop, as some participants actually did. Besides the main document, we prepared its shorten version on 6 pages in order to summarize the main points of the scenarios.

Moderators and Rapporteurs: All facilitators received the Instructions Document customized for each one of the 6 groups. Besides that there was a 1-page cheat sheet with all the important points from the Instructions Document. We organized 2 main trainings of the moderators and rapporteurs in order to synchronize our approach. All facilitators were employees of the Technology Centre ASCR. The main facilitator was Lenka Hebakova, the Czech manager of PACITA.

Keynote speaker: We had decided to invite a keynote speaker who would address the most appealing issues of ageing population in the Czech Republic. In doing so, we invited Jirina Kocourkova from the Faculty of Sciences of the Charles University in Prague to present her piece on the Demographics of Population Ageing in the Czech Republic.

Recruitment Process and Participation

We recruited the participants for the Scenario Workshop mostly through our existing mailing lists. The registration tool was set up for a maximum of 40 participants, which we almost reached at the time. The aim was to have an equal number of participants representing 1) employees in the health care sector; 2) local and national decision-makers; 3) providers of technology solutions; 4) the senior community; 5) researchers; 6) and volunteering organisations. At the registration, participants opted for the group they wanted to participate in. This way we guaranteed more-or-less equal division of participants into groups. At the same time, we prevented a potential confusion regarding who is member of what group.

The workshop had 36 participants. A majority of the participants came equally from the Government of the Czech Republic (22 %) and several NGO's (22 %). The most represented Ministry was the Ministry of Health (4 participants), followed by the Ministry of Education, Youth and Sports (2 participants) and the Ministry of Labour and Social Affairs (2 participants). Concerning the NGO's, the most represented one was the Council of the Czech Seniors (3 participants), followed by Life 90 (2 participants). The next most represented groups were hospital employees (17 %) and businessmen (17 %). The most represented hospitals were the Charles University Hospitals in Prague and Pilsen (3 participants), while the most businessmen came from the consulting firms (3 participants). 14 % of the participants came from the universities, most of them from the Charles University in Prague (4 participants). Remaining 8 % came from the Prague municipalities. As the Scenario Workshop was organized in the capital city, 89 % of the participants came from Prague. Genders were represented equally in the workshop (50 % were men, 50 % women). Concerning the education of the participants, 39 % held post-graduate degrees, 31 % graduated from master programs and 3 % from bachelor ones. For 28 % of the participants, this information was not available. All in all it was a fairly good representation of different stakeholders, notwithstanding that two parliamentarians absented at the last moment. For visualization, see the charts in the Appendix A.

Organisation of the Workshop

The Scenario Workshop was held on the premises of the Technology Centre ASCR in Prague 6. The 36 participants were divided into 6 groups of 5-8 for the group work; each group took place in a separate room, each one of which has its specific colour in order to facilitate the navigation for the participants (see the Appendix A). Likewise, a specific colour belonged to a concrete moderator and rapporteur. The homogenous groups were distinguished by numbers (1-6), heterogeneous by letters (A-F) in order to avoid confusion, too. All of this was as well reflected by the badges of the facilitators, which, besides names, displayed one colour and number for the homogenous group and one colour and letter for the heterogeneous one. This way, all the participants had to remember, in terms of the navigation on the premises, was two different colours and symbols – and they could easily locate either their facilitator or the room they should be in. The list and composition of participants can be found in the Appendix A.

The workshop started with a short introduction to the PACITA project, the scenario workshop method, and a quick walk trough of the scenario document. The expected outcome from each phase of the workshop was explicitly explained before each of the three phases with group discussion.

8.45 – 9.00: Registration

9.00 – 9.05: Welcome by Lenka Hebakova

9.05 – 9.20: Keynote speech by Jirina Kocourkova:

Demographics of Population Ageing in the Czech Republic

9.20 – 10.00: Introduction to the scenario document

10.00 – 10.30: Phase 1: General response to the scenarios

10.45 – 11.00: Coffee break

11.00 – 11.45: Phase 2: How would reality be in scenario 1, 2 and 3?

11.45 – 12.30: Plenary session – presentation of phase 2

12.30 – 13.30: Lunch

13.30 – 14.45: Phase 3: Formulation of the participant's visions

14.45 – 15.00: Coffee break

15.00 – 15.45: Plenary session – presentation of participant's visions and recommendations

15.45 – 16.00: Concluding remarks, thank you and good bye

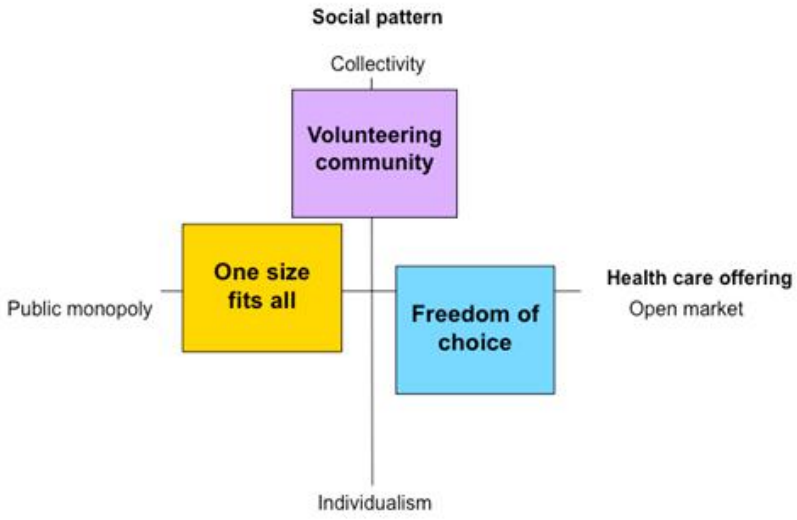
Responses to the Scenarios

The scenarios address choices the politicians can take for improving the future care services for the seniors– and the dilemmas they are faced with. The two main concerns in our scenarios are:

- Is it the public or private health care providers who are providing future seniors care?
- How do the seniors and other groups in the society organize themselves in order to meet the needs for care?

We have chosen to look at these two main concerns as two axes. On the horizontal axis the one extreme is that the government decides which technologies everybody will be entitled to, and the other extreme is that people can choose freely themselves from an open marked. On the vertical axis, the one extreme is that the seniors themselves, their relatives and the community cooperate and help out, and constitutes the major resource in the seniors care. The other extreme is that each senior has to find and choose his or her own care services.

To illustrate the consequences that might follow different decisions three scenarios have been developed. The three scenarios are not the aforementioned extremes but they include a combination of them. The way they address the main concerns is illustrated by where they are located in the coordinate system (see figure below):



The three scenarios illustrate different ways the community can develop. They show in particular how the health care services may develop, how the municipalities may be affected by increased government control, a stronger private sector or a better organised voluntary community. The scenarios also illustrate what municipalities can do to tackle the different reality models.

It was generally perceived that the solutions offered in the 'One Size Fits All' scenario are closest to the reality in the Czech Republic. A standard set of services, tailored to each user's needs, will constitute a basic offering for all citizens. The service offerings described in the 'Freedom of Choice' scenario and the 'Volunteering Society' scenario will be added based on needs and availability of these services. However, there are several choices in what way these services are developed, implemented and stimulated.

Scenario 1: One Size Fits All

'One Size Fits All' is based on the assumption of lack of labour in the future, and it describes a large-scale governmental initiative using technologies to make people more self-reliant. The local municipalities provide most of the public support services. However, national standards now determine which home care technologies and services the municipalities must provide.

All groups were asked to give their immediate reactions to the three scenarios: *positive and negative feedback. Are they realistic? Possible? Desirable? Why / why not?* Below are the main reactions to the scenario 1.

General Response to Scenario 1

As per the participants, this is the most realistic scenario of the three, mostly because the infrastructure is already more or less in place. Some sort of differentiation between basic and extra care is in place, too. Plus, there is a tradition that the government provides for the healthcare of its citizens. However, because it is a universal scenario, there is very little space to accommodate individual needs. Low response time of the public administration could result in outdated health kits – because of time consuming calls for tender and legislation process. Lack of sufficient information on innovations for seniors is also of concern.

The scenario gives too much emphasis on technology, which is only a part of the complex problem of an ageing society. Moreover, a greater use of ICT would lead to a greater demand for the social work as seniors need assistance with technology selection, user instructions, quality assurance and time management. Left alone the fact that, according to some participants, there is a reluctance of healthcare practitioners to change the way they work and learn new things – mostly because of time constraints.

Positive Responses to Scenario 1

Scenario 1 provides for *risk-free self-sufficiency* – "when you got lost, they will find you." Equal right to "medical kit" defines standard that everybody can claim regardless of his/her diagnose. Its definition would stem from the most frequent health problems of seniors (impaired mobility, dementia, etc.). The more a person is sick, the better solution for him this scenario is.

The scenario builds on a realistic and *traditional approach* in the Czech Republic. People expect that the government provides for their healthcare. Readiness of the existing infrastructure of health care services is in its favour, too – existing care facilities can be easily adapted.

Assistive technology of the basic-care medical kit will be accessible for all. Technological progress will help to better cope with the change of circumstances. Eventually, the devices will get cheaper, too.

Negative Responses and Concerns Related to Scenario 1

The scenario is restrictive as it does not reflect the broad spectrum of needs of seniors. It stimulates a *passive approach* – the public relies on the fact that "the state will take care of" – the decision on a type of service does not belong to seniors who voluntarily refrain from it. Consequently, it could end up in two extreme situations: in their refusal to use technologies or in their isolation from the rest of the society.

Moreover, there is a big risk of *rigidity* of the competent authorities in the Czech Republic, stemming from a slow legislative response to the current issues and coordination between actors in the public sector. There is insufficient communication within the administration in all directions.

Financial resources for implementation (state efficiency) are questionable, too. Small municipalities will not have the trained personnel for advanced-technologies management. Generally, there are not enough qualified care-takers.

It remains as well unclear how to tackle *data security* and *privacy issues* as there exists a very realistic threat of abuse of sensitive data. Hackers prefer central databases with outdated security measures.

Dilemmas in Scenario 1

- *Evidence-based policy-making* clearly needs to improve. The public administration does not use much of analysis, data, foresight, statistics, strategies etc. There is a reluctance of politicians to take into account the "evidence". The political representation is not prepared for an ageing population, which is not seen as a policy priority.
- Many questions arise concerning the *care for specific groups* that do not "fit" into a universal solution, or otherwise called the dilemma of priorities versus needs. Should standard be based on the most common problems of the seniors? Should state provide technologies for all diagnoses equally?
- *Privacy* could as well be a problem, especially when there is a dilemma of deciding for people with dementia or other disabilities.
- *Financial resources* – this scenario could be expensive (expensive technology) but at the same time less costly (less residential facilities, less expenses).
- *Social involvement* of seniors – more technologies could lead to a social isolation or, vice versa, to more activity in the community.

Other Issues Regarding Scenario 1

- *'Ageing Literacy'* – lifelong preparation for the old age (since primary school), motivation for individual responsibility for one's age and health prevention. Change of mentality. Timely start to educate and train future senior citizens (at the age of about 50). Chances for new degree programs and courses.
- *Technological progress* – potential for the future. Support for the development of assistive technologies from the public sources. Technologies should be more seniors-friendly – plus special technology-support activities for seniors with dementia (better movement and self-sufficiency). More communication technology, not only health protection or monitoring.
- *Use (not abuse) of data* for introducing new technologies and services.
- *Role of family* and community – more "part-time jobs" for seniors.
- *Role of media* – more positive examples and images of ageing.

Differences from the Groups

The group of seniors saw this scenario, in contrary to the predominant opinion, as a non-realistic scenario in the Czech Republic. They called for a necessity of quantifying the financial cost compared to the financial possibilities in the country. They saw the problem of ageing population through a prism to which the others must "grow up" first. The group refused to focus only on the task, instead an extensive discussion on the topic of ageing and social inclusion of seniors was led (Group 4).

Scenario 2: Freedom of Choice

'Freedom of Choice' is based on a new political system where the incentives for care recipients go directly to the user. This scenario furthermore describes a society where you can buy a great variety of care services from the open market. Everyone in need for care is entitled to incentives and financial support depending on his or her health condition. The municipality's responsibility is now to ensure the existence of an adequate supply of care services for those living and residing there (national standards or higher).

All groups were asked to give their immediate reactions to the three scenarios: *positive and negative feedback. Are they realistic? Possible? Desirable? Why / why not?* Below are the main reactions to the scenario 2.

General Response to Scenario 2

Scenario 2 is very individualist – suitable only for seniors who are financially secure and used to carry out important decisions in order to choose appropriate services for them. As cognitive health is quite important in this case, the scenario is more suitable for younger seniors. There are some similarities to the current system of care allowances paid directly to the beneficiaries, who can decide freely on a provider. What is positive about this scenario is that there are many cases when social services are provided on a commercial basis with a higher quality – provided there is reliable information available for seniors to decide for themselves.

An unrealistic idea, however, is to apply this scenario to the healthcare services. In the Czech Republic, there are two collateral systems of financing – one for the social care, the other for healthcare. These two systems are mutually incompatible. Healthcare is a different field, which cannot be completely liberalized, unlike the social sector. Moreover, in practice, social-care allowances did not work very well as seniors are not prepared to purchase services. Left alone missing support of politicians.

Positive Responses to Scenario 2

The described scenario would probably provide a significantly *better quality* of care, in contrast to only a slight increase in cost. The market could offer options and powerful tools to prevent "rapid" ageing. This is related to the possibility of greater directness / *individuality* of services. People naturally choose such a combination of services that best suits (on condition that it will be affordable).

The scenario is also characterized by high *transparency*. Distribution of funds at the level of the individual (who decides on the quality with all the necessary information) would provide the highest quality care and product / technology. It resembles the current system of care allowances.

Negative Responses and Concerns Related to Scenario 2

It is quite difficult to ensure *minimum care for everyone* and everywhere. The market mechanisms strengthen the natural inequality. There is a risk that it would not ensure even the basic level of care for some groups. In this scenario, there is a need for a very strong surveillance / community planning to ensure at least a minimum standard for all and everywhere (remote areas with insufficient market potential, etc.).

Moreover, there is no responsible and impartial provider of *information* (or of a specific solutions), which would ensure the efficient functioning of the market – hence, difficult to assure a correct and objective assessment of specific needs of seniors and/or correct use of funding (whether deliberate or due to ignorance). So this scenario is *prone to corruption*.

A negative feature of this scenario is, as well, a possibility of undue *division of demand*, such as when two adjacent seniors would demand virtually the same service from different suppliers (dual travel costs, etc.). Therefore, it is needed to aggregate the demand through communities (third scenario).

Given a *lack of clarity*, the less technologically savvy or uninformed may not be able to orientate on the market. This is a specific group, for which it is necessary to create a mechanism that will be able to assess and choose an appropriate solution.

Dilemmas in Scenario 2

- For the given scenario, there is currently *minimal readiness*. It is difficult to assume that this situation will change in the next 10 years.
- *Unqualified decision-making*. Lack of good medical examiners / gerontologists (educated in the field to assess the patient's condition).
- *Prone to corruption*. Due to limited information and nature of the target group, there is much room for abuse of the system by offering irrelevant services with the sole aim to earn money.
- The *volatility* of state funding could result in an immediate diversion of private entities. Quality of care could very quickly fall in a situation with limited financial resources available on the market (caused e.g. by restricted contributions from the state, immediate withdrawal of private entities from the market, etc.), or in an uneven / insufficient competition (monopolization).

Other Issues Regarding Scenario 2

- Transparent market and comprehensive assistance in decision-making assured by the community. Need for more effective *community planning* and for a trusted intermediary for non-profit / voluntary sector organizations.
- There are a number of cases where services are provided on a commercial basis with a result of higher quality. With an appropriate *quality assurance*, the example of care for the seniors could be one of them.
- More space given over to market could *accelerate the development* of technology for the care of the seniors, provided that the demand will be adequately informed. The growth of information is prerequisite for technological development.
- Systematic *education of society* and preparation for retirement. Inclusion of new curricula in education (respect for old age, technology options, legal aspects, financial contributions, etc.)
- Systematic *evaluation* of the allocation and use of grants.

Scenario 3: Volunteering Community

'Volunteering Community' is based on volunteering people as the key resource for the community and for each other. This could include the seniors themselves, their relatives, charities, neighbours, school children etc. The municipality's main role is to mobilize coordination of the volunteering organisations. The local municipalities are responsible for ensuring that there is a proper healthcare for its inhabitants, including monitoring the quality of care provided. The local municipalities are required to deliver some health services, to manage licenses for private operators and to mobilize coordination of the volunteering organisations.

All groups were asked to give their immediate reactions to the three scenarios: *positive and negative feedback. Are they realistic? Possible? Desirable? Why / why not?* Below are the main reactions to the scenario 3.

General Response to Scenario 3

Scenario 3 describes a system, which cannot exist in the Czech Republic on its own but only as an addition to the systems described in the former scenarios. It is a good idea, especially from the perspective of social inclusion of seniors and community revitalization. People already know that they must take care of each other, too; they usually do not rely solely on the state assistance. Currently, this applies mostly to the family level – "informal volunteer care" represents a significant part of (especially social) care.

Furthermore, this system operates to some degree in small municipalities, where there is a common practice of shared care – neighbours take care of each other. Anyway, although small municipalities can support such activities of mutual assistance and volunteering, a question remains if it will work in a more anonymous environment – such as the one in the capital city, Prague.

The problem is that a past tradition of community life did not preserve in the Czech Republic. As there is no education for volunteering, it is difficult to start it over again. It would need to change radically the care system, for which there is no political will.

In such a system, allowances should flow directly to individuals, and not through institutions. In case a senior cannot decide independently, decisions must be taken by a family or community, for which there is only a small readiness of the society and / or the public administration. On top of that, the role of municipalities is very demanding – will they be able to perform all their roles in a qualitatively and quantitatively appropriate way?

Positive Responses to Scenario 3

The most positive feature of this scenario is that it favours the *freedom of choice* – the inclusion of the seniors in society according to their own choice. In doing so, it meets one of the objectives of health and social care. It gives as well a possibility of further *inclusion* on the labour market – requalification opportunities, personal satisfaction / self-realization – in order for the seniors to feel useful and needed.

Being an initiative of people who are interested and motivated, the *voluntary scheme* of this scenario could ensure a quality care. In order to support and coordinate volunteers (community, church, interest groups), there should be efforts to establish or revitalize the community centres.

Most probably, Scenario 3 is *less financially demanding*. Appropriate use of new technologies to support the voluntary scheme can support the health system; mostly the use of new technologies with a socializing element.

This scenario has potential to improve the quality of life for groups of all age – providers included – as it represents timely and flexible response to current needs and problems. It seems that its response is much more *flexible* than governmental.

Negative Responses and Concerns Related to Scenario 3

There is a potential for an *invasion of privacy* and intimacy of the clients, which depends on the age and professional focus of the seniors. Likely, this includes fear of abuse of data and distrust of strangers. Especially, poor previous experience prevents the positives.

Insufficient experience with such a system – there is nothing to build on. It is not yet legally regulated ... incl. solutions to the financial side of things. Lack of motivation and education for volunteering could lead to lack of volunteers.

Dilemmas in Scenario 3

- If not *coordinated*, it leads to an ineffective assistance. The question of obligation, competence and cooperation of representatives of the state administration in order not to block the volunteer assistance. A collaboration across sectors is not currently working very much. Plus, inability to use good examples in practice.
- Prone to fraudulent conduct and *inadequate* or unavailable care in case of undeveloped community networks and not volunteer-friendly society.
- Lack of *communication* between younger and older people as a consequence of the atomization of families.
- *Distrust* resulting from bad experiences.

Other Issues Regarding Scenario 3

1. Developing a culture of *community events* in smaller units.
2. Increased *mobility* of seniors and reduction of their fear.
3. Suitably adapted technology for the seniors of over 80 years (*emergency care*).
4. The development of intergenerational *communication and socialization*. Education for the seniors' care, which becomes a natural duty.
5. *Trust* – strengthening and deepening trust between people. Increase empathy in society.

General Response to the Scenarios

A problem of technology to improve quality of life of seniors is perceived as marginal (Group 1, 2, 4) – see also negative experiences with the use of new technologies in the contemporary gerontological practice (Group 1). What is perceived as far more important is a social dogma, through which seniors are seen as a burden to the society – with a reducing quality of life in the old age (Group 3, 4). The project does not reflect on other factors such as activities for seniors, family background, respect for seniors, and social inclusion of seniors. Group 4 sees this as the biggest challenge for ageing society – starting with behaviour of young people (lack of interest) and ending with an image of seniors in the media (Group 4).

The immediate reaction to the discussed scenarios by the representatives of the Ministry of Health was scepticism stemming from the experience of slow decision-making of the key institutions and their inflexibility (Group 1). There was a repeatedly-emphasized danger of misuse of technology and personal data as well (Group 1). On the contrary, there was a group who did not identify any ethical or legal problem associated with the use of technology monitoring the personal data of patients (Group 4). Anyway, it is expected that there will be a shortage of nurses in the future and that new technologies could, to a certain extent, substitute this lack of the internal clinics and departments (Group 1).

For the participants, it is obvious that the scenarios originated in Norway. Moreover, they perceived them as too general and little sophisticated. For a better understanding, they should be more tailored to the local conditions – with a more described context of the situation and quantification of the data (Group 2). Even though there was a consensus that the issue of ageing-society definitely calls for a more comprehensive approach, it was very well perceived that the workshop opened a discussion in this regards (Group 1, 4).

The result of the discussions is an idea that the best would be a combination of all three scenarios. The State should provide a standard care for seniors, allowances for a special care (combined with a market-based practices) and guarantee a quality of volunteers (Group 1,2, 3, 4, 5, 6). A solution, however, always depends on funding and people (Group 4, 5).

Analysis and Synthesis of the Visions and Recommendations from the Czech Republic

The participants were reallocated into the heterogeneous groups for this part of the workshop. The new groups were asked to discuss and propose their own visions about the future elderly care, and identify strategy and political choices that would be central in this vision. The participants prioritised and formulated 1) 2-3 visions for what kind of elderly care services the participants want in the future and 2) policy recommendations needed to achieve these visions. The complete set of visions and recommendations are found in appendix A.

The most discussed visions[13] of the Scenario Workshop in the Czech Republic were concerning the two-tier healthcare system (33 %), dignified ageing (27 %), volunteering community (20%), information society (13 %), and home-based ageing (7%). After they had formulated their visions, the participants proposed several policy recommendations and identified specific actions needed in order to fulfil these visions. The most discussed policy recommendations[5] were those calling for a normative role of the State (31 %) and an effective coordination and financing (31 %), followed by the recommendations on comprehensive legal framework (13 %), evidence-based policy-making (13 %) and ageing literacy (13 %). For visualization, see the charts in the Appendix B.

For purposes of this report, the visions and policy recommendations are clustered in the following categories:

1. Recognition and acknowledgement of individual needs
2. Self-determination, autonomy and freedom of choice
3. Guaranteed basic care provision
4. Participation and inclusion
5. Quality assurance

Overview of Visions

1) Recognition and Acknowledgement of Individual Needs

Visions

Ageing perceived as a dignified part of life. New technologies help the informed seniors in active, healthy and socially-fulfilling life.

Recommendations for these Visions

- The normative role of the state and media – pointing to what is desirable. Public television should broadcast more programs about, for and with seniors (via e.g. quotas, financial support programs, etc.):
    - Media coverage of the good national and international practices of intergenerational cooperation. More 'senior' moderators in television, radio.
    - Promotion of healthy lifestyles – more preventive programs – Ministries, health professionals, schools and media.

[13] Based on the occurrence of the term or its meaning in the set of 15 visions recommended by the working groups – see Appendix B

- Coordination of public-administration bodies (e.g. between the Ministry of Health, Ministry of Labour and Social Affairs, Ministry of Education and Ministry of Culture).
- Education – to include a subject of ageing into primary and high school curricula.
- Better awareness of seniors (e.g. courses for future seniors, counselling centres, call centres, on-line applications, etc.).
- Development of technologies adapted better to the requirements of seniors in electronics, but also in architecture and transport.
- Formulating a clear and long-term national strategy for an ageing population, which would include support for assistive technologies, inclusion of the independently-acting seniors, exchange of international experiences, and anticipation of the future potential challenges.
- Proper legislative framework for the use of technology and data protection.
- Sufficient funds for early detection of dementia.

2) Self-Determination, Autonomy and Freedom of Choice

Visions

Information society where people are well informed, understand the system and are able to decide on their options (accessible and comprehensive information and legal services, conscious health monitoring, etc.).

Recommendations for these Visions

- Assistive-technology providers (whether state, municipalities, or community) should focus on its availability and simplicity (intuitive and easy to operate).
- Coordinated and effectively communicating public administration to ensure continuity in the system.
- Clear legislative framework that provides for mandatory minimum standards of social and health care and creates conditions for a possibility of choice.
- Regulation of public media to ensure adequate awareness of seniors.
- Support legal services for seniors.

3) Guaranteed Basic Care Provision

Visions

There is a two-tier healthcare system with a state-guaranteed basic care and extra services for those who can purchase them. At the same time, seniors can receive individualized health and social care with regard to their specific health condition and situation. The care system is coordinated, effective and without fear of misuse of funds.

Recommendations for these Visions

- The tiered healthcare system based on prevention, ensuring the standard basal level of care to all and favouring the additional work by families / volunteer / community.
- Financially sane care system that has enough resources for its operations, allows long-term sustainability, ensures supply of essential services (e.g. housing) and builds on the cooperation between the relevant Ministries.
- Political system – Frequent changes in political representation halts long-term planning. It is a necessity to create and implement a uniform policy of quality ageing across the whole political spectrum.
- High-quality and comprehensive legal framework for the functioning and setting of care system – includes standards definition, interface between health and social care and between state and private care.
- Clear rules for financing of health and social services to ensure adequate funding for the system and rewards for its employees – with a help of the European funds.
- To improve quality and to assure capacity in care centres – to ensure adequate rehabilitation and other services capacity as per the needs of seniors and their dependency rate. Provisions for affordable (small-area / social) housing.
- Assessment according to actual needs, not as per administrative procedures. Quantification of actual needs – based on the evidence-based approach, such as comprehensive monitor of trends in the number of seniors and their requirements for care.
- To support prevention and health education and active approach to ensure quality ageing and healthy lifestyle for people of all ages.
- Existence of interface for the development of assistive technology

4) Participation and Inclusion

Visions

People feel mutual solidarity and participate actively in a number of voluntary activities, which is highly appreciated by the society. The care of seniors is based on a combination of state and community volunteer activities.

Recommendations for these Visions

- High decentralization and de-institutionalization of social care – there is a dense network of day care and facilities that are staffed adequately.
- This requires coordination of public-administration bodies and relevant actors at all levels (e.g. the Ministry of Health, Ministry of Labour and Social Affairs, Ministry of Education and Ministry of Culture).
- General awareness raising and education to build a socially conscious society with active links across social classes. The formulation of educational strategies in social care, for:
    - Social service workers (included employment of the unemployed and support for requalification)

    - University courses should require practice in the care of seniors and should guarantee dissemination of the latest scientific knowledge
    - Elementary and secondary schools – courses on ageing
    - Seniors
- There is a methodology in place for volunteer work and its appropriate recognition.
- A clear long-term national strategy for an ageing population, which would include:
    - Support for inclusion of seniors, their proactive approach and independent decision-making
    - Measures to motivate people to prepare early for retirement
    - Active exchange of national and international experience
    - Anticipation of the potential future challenges
    - State aid (e.g. tax relief) for the private sector

5) Quality Assurance

Visions

The seniors can stay at their own home as long as possible (to avoid change management).

Recommendations for these Visions

- Decision-makers must be aware of the needs of seniors – collaboration with experts; take into account the entire demographic system and leverage the known demographic data.
- Create conditions for social and healthcare cohesion.
- Mutual communication between health and social care organizations.
- Support for family, assistive technology, respite care (temporary relief to those who are caring for family members) and palliative care.
- Consultancy services for all generations, especially for seniors.

Alignment with National Policies

Looking at the visions and recommendations that were discussed in the Scenario Workshop, we can distinguish 5 areas of importance regarding the national policies in the Czech Republic:

1) Normative role of the State
2) Comprehensive legal framework
3) Effective coordination and financing
4) Evidence-based policy-making
5) Ageing literacy

These areas will be further discussed and compared to the existing social and healthcare services and strategies. How close or far are these policy recommendations from the actual strategies and plans?

Normative Role of the State

There are two dimensions of the recommendations concerning the normative role of the State: one relating to formulation of a clear national strategy in this regard, the other more focused on media and other way of its presentation to the general public.

- The State should act on its normative role and lead toward what is desirable. In order to tackle the frequent changes of political representation that halt a long-term planning, there is clearly a need for a uniform policy across the whole political spectrum. Therefore, the State should formulate a clear and long-term national strategy for an ageing population, which would include:
    - Support for inclusion of seniors, their proactive approach and independent decision-making about assistive technologies
    - Measures to motivate people to prepare early for retirement
    - Active exchange of national and international experience
    - Anticipation of the potential future challenges
    - State aid (e.g. tax relief) for the private sector
- The State should regulate the public media to ensure adequate awareness of ageing. Public television should broadcast more programs about, for and with seniors (via e.g. quotas, financial support programs, etc.):
    - Media coverage of good national and international practices of intergenerational cooperation. More 'senior' moderators in television and radio.
    - Promotion of healthy lifestyles – more preventive programs – Ministries, health professionals, schools and media.

➔ ***Current status in the Czech Republic***: In 2013, the Government approved the National Action Plan Supporting Positive Ageing 2013-2017. This Plan is the third one in this area the government has approved so far (I: 2003-2007; II: 2008-2012). The advantage of the

third plan – in comparison with the previous ones - is that it shall contain also the monitoring indicators measuring the implementation success as an annex.

Comprehensive Legal Framework

- The State should guarantee a high-quality and comprehensive legal framework for the tiered healthcare system (based on prevention, ensuring the standard basal level of care to all and favouring the additional work by families / volunteers / community), which would include:
    - Definition of the mandatory minimum standards of social and health care
    - Provisions for interface between state and private health and social care
    - Provisions for proper use of technology and data protection
    - Provisions for volunteer work and its appropriate recognition
    - Provisions for freedom of choice of social and health care

➔ ***Current status in the Czech Republic:*** Two-tier healthcare system exists in some form today. There is a definition of minimum standards in many areas; extra care is available, too. Quality of the system is questionable, though. It would also need to grow in quantity of covered topics and situations – see standards in social care, volunteer work, and private care.

Evidence-Based Policy-Making

- The decision-makers must be aware of the needs of seniors; they should collaborate more with experts, take into account the entire demographic system and leverage the known demographic data.
- Assessment must be done according to the actual needs, not as per the administrative procedures. To meet this goal, there is a need for quantification of the actual needs – based on the evidence-based approach. The decision-makers should comprehensively monitor trends in the number of seniors and their requirements for care. In doing so, they should improve the quality and assure the capacity of care centres in order to ensure adequate rehabilitation and other services capacity as per the needs of the seniors and their dependency rate.
- Assistive-technology providers (whether state, municipalities, or community) should focus on its availability and simplicity (intuitive and easy to operate). They should develop more technologies adapted better to the requirements of seniors in electronics, but also in architecture and transport. There should be an interface for the development of assistive technology in place.

➔ ***Current status in the Czech Republic:*** Requirements of the administrative procedures are not in favour of the actual needs of seniors. Availability of care is limited in some areas, or too generous in others. Real assessment base on the quantification of needs is missing. In 2012, the Ministry of Health signed a collaborative agreement with WHO, which aims at introduction of the enhanced analytical products for planning, monitoring and evaluation of health situation and inequalities in support of decision making and reform processes responding to the health needs.

Effective Coordination and Financing

- Coordination of public-administration bodies (e.g. between Ministry of Health, Ministry of Labour and Social Affairs, Ministry of Education and Ministry of Culture) and mutual communication between social and health-care organizations (so called social and healthcare cohesion) to ensure continuity in the system.
- Financially sane care system that has enough resources for its operations, allows long-term sustainability, ensures supply of essential services (e.g. housing) and builds on the cooperation between the relevant Ministries – with a help of the European funds.
- High decentralization and de-institutionalization of social care – there is a dense network of day care and facilities that are staffed adequately
- Special emphasis on support for families –respite care (temporary relief to those who are caring for family members) and palliative care; provisions for affordable (small-area / social) housing and sufficient funds for early detection of dementia.

➔ ***Current status in the Czech Republic:*** There are two collateral systems of financing – one for the social care, the other for healthcare. These two systems are mutually incompatible. Healthcare is a different field, which cannot be completely liberalized, unlike the social sector. Moreover, in practice, social-care allowances did not work very well as seniors are not prepared to purchase services. On top of that, social and health care is within agenda of two different Ministries (Ministry of Health and Ministry of Labour and Social Affairs), which halt any effective policymaking as these governmental bodies do not communicate effectively.

Ageing Literacy

- The State should formulate a clear educational strategy in social and healthcare:
    - Courses for social-service workers (included employment of the long-term unemployed and support for requalification)
    - University courses should require practice in the care of seniors and should guarantee dissemination of the latest scientific knowledge
    - Elementary and secondary schools should include courses on ageing in their curricula
    - Better awareness of seniors (e.g. courses for future seniors, counselling centres, call centres, legal services, on-line applications, etc.)
    - General awareness raising to build a socially conscious society with active links across social classes
    - Prevention and active approach to ensure quality ageing and healthy lifestyle for people of all ages

➔ ***Current status in the Czech Republic:*** There is no existing educational strategy in terms of Ageing Literacy. Notwithstanding that, in 2012, the Ministry of Labour and Social Affairs established the Government Council for Ageing – Work Group for Age Management and Prize for the Application of Age Management for these very purposes. Results remain to be seen.

Summary and Concluding Remarks

Although this method is suitable for guided discussions with a goal to obtain a spectrum of views and opinions, it would need some refining in order to get more sophisticated results (materials for prospective studies) that are easily comparable among the working groups. For future, more attention should be given especially to the adaptability of scenarios to local conditions. Concerning practical arrangements, it requires, to some extent, a little more time for introduction to the workshop method – in order to explain the "rules of the game" according to which the workshop operates. Each participant defends his own standpoint stemming from his expertise (e.g. civic associations, researchers, etc.) so it is difficult to integrate their opinions and to keep the discussion within the limits of the task. What is particularly challenging is to discuss the future. The participants found it difficult to imagine a situation in 10 years – there was a tendency to talk about today. Plus, many of them saw the proposed scenarios as unrealistic and incomplete – too specific in unimportant details while lacking quantification of needs and resources. Formulating a vision was particularly difficult. This was caused partly by the reshuffle of groups, partly by the fact that participants were not certain to what extent visions are based on scenarios. There was as well a specific reluctance to forget about numbers when creating visions, too.

Most participants of the homogeneous and heterogeneous working groups assumed a pro-active attitude, which led to a stimulating debate about the issue. Not all of them, however, could have stayed till the very end of the workshop because of their professional obligations. This seems to be a problem of all the activities that require an afternoon participation, which often falls to 70 % compared to the morning phase. A question remains if it was important to dedicate some time to the presentation of the group work in the plenary or if it would be better to skip this phase – mostly because a majority of participants had pretty much passive role in the plenary.

Content-wise, the proposed scenarios were little "challenging" – targeted at the (Norwegian) middle class and lacking more extreme cases – say a rural religious woman, or a disabled AD patient. On the other hand, form-wise, the scenarios were too "challenging" – too demanding on participants (homework reading) and time (60 minutes for 6 people to discuss a complex issue). Method-wise, the scenarios did not properly distinguish among independent and dependent variables. Some dependant variables (such as relocation, social activity, medical examination, etc.) were used instead of / mixed with independent ones (e.g. social status, family status, residency, income, health condition, etc.). "Personas" should better be defined only by four or five independent variables, which would respond to changing scenarios (dependent variables) – see the following table for an example.

Personas	Social Status	Family Status	Residency	Income	Health Cond.
1	Construction	Divorced w/children	Municipality	Low	AD
2	Academia	Widow/er w/children	Rural Area	Medium	BPD
3	IT	Married w/o children	City Centre	High	DD

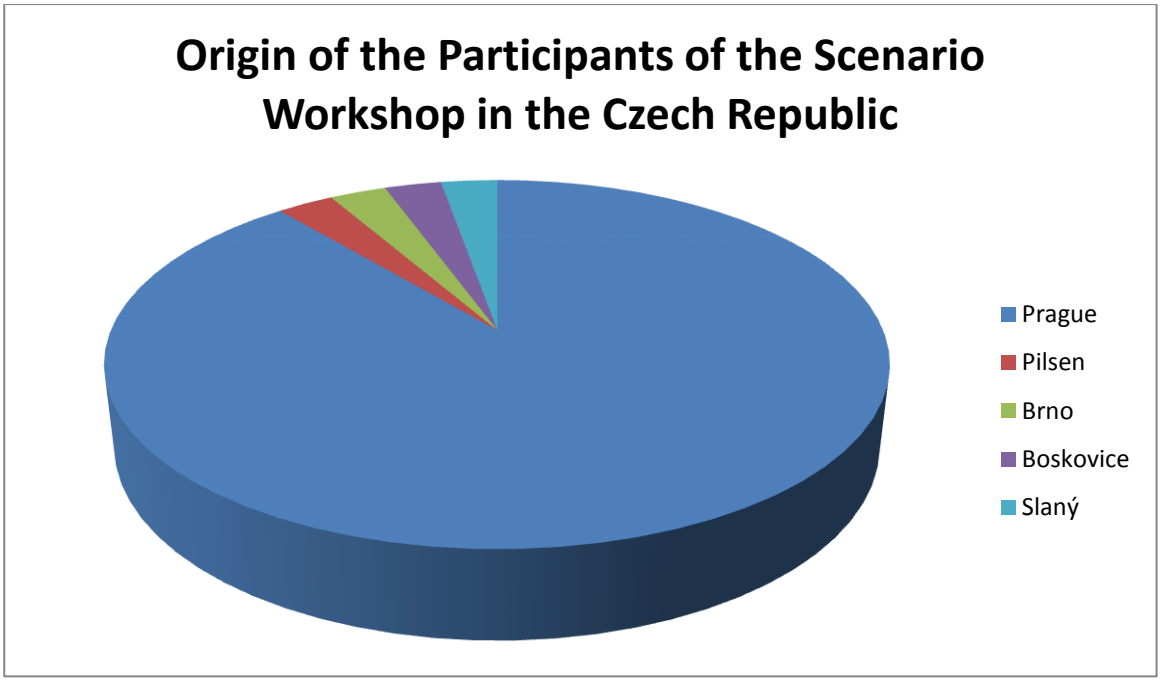
AD – Alzheimer Disease, BPD – Bipolar Disorder, DD - Disabled

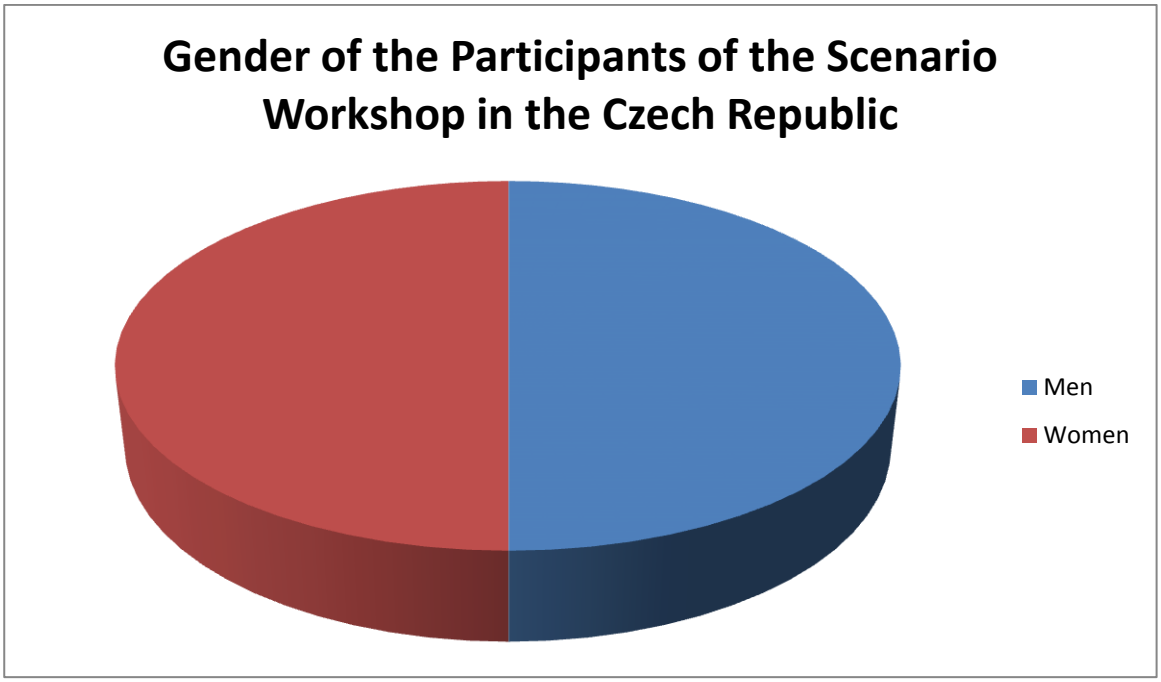
Appendix A: List of Participants in the Scenario Workshop

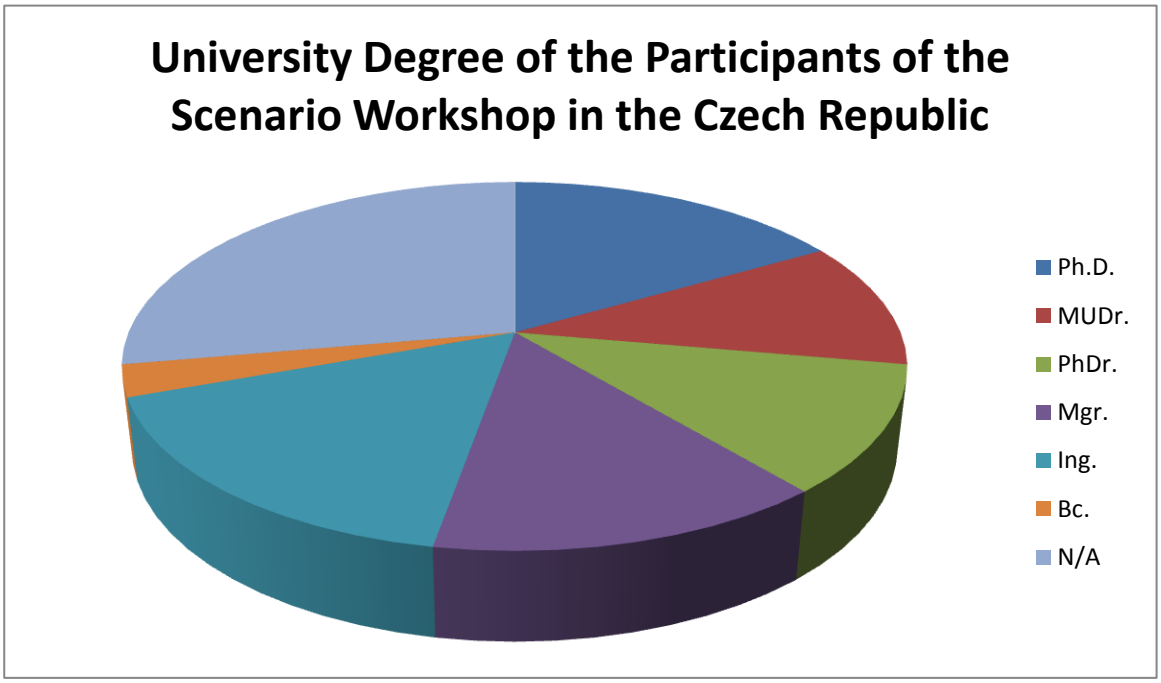
	#	Surname	Name	Organisation	He
Scenario 1: One Size Fits All	1 - HEALTHCARE	Dalíková	Jana	Ministry of Health, Department of EU Funds	D
		Krombholz	Richard	Bohnice Psychiatric Hospital	E
		Kysilka	Pavel	Ministry of Health, Department of EU Funds	B
		Mádlová	Pavla	Charles University Hospital in Prague, Department of Geriatrics	C
		Tošnerová	Tamara	Charles University Hospital in Prague, 3rd Faculty of Medicine	F
		Vostřáková	Ludmila	Ministry of Health, Department of Health and Social Care	C
	2 - POLICYMAKERS	Bednářová	Renata	Ministry of Health, Department of EU Funds	A
		Klinecký	Tomáš	Prague City Hall, Department of Health and Social Care	
		Koucká	Marta	Ministry of Labour and Social Affairs, Committee on Social Inclusion	C
		Nuñez	Lucie	Ministry of Education, Youth and Sports, Department of Research and Development	F
		Ondrouchová	Antonie	Ministry of Education, Youth and Sports, Department of Strategy and European Affairs	E
		Pechová	Denisa	Ministry of Labour and Social Affairs, Committee on Social Inclusion	A
		Petrenko	Jana	Coalition for Health (NGO)	
		Vostrý	Karel	Union of Employers' Associations, Section of International Cooperation	D
Scenario 2: Freedom of Choice	3 - BUSINESS	Budský	Šimon	3P Consulting, s.r.o. (consulting)	
		Fiala	Radek	CleverTech (assistive technology)	A
		Holkup	Tomáš	Linet, s.r.o. (diagnostic instruments)	C
		Roupcová	Eva	Metropolitan District of Prague 22 (social care provider)	B
		Šveřepa	Milan	3P Consulting, s.r.o. (consulting)	
		Veselík	Zeno	ABC Works CZ, s.r.o. (consulting)	
	4 - SENIORS	Malý	Alois	Council of the Czech Seniors (NGO)	
		Městková	Julia	Life 90 (NGO)	C
		Pernes	Zdeněk	Council of the Czech Seniors (NGO)	
		Stožický	Alexandr	retired doctor of medicine	D
		Taraba	Milan	Council of the Czech Seniors (NGO)	
		Vondráček	Lubomír	retired doctor of laws and medicine	B
S3: Volunteering Community	5 - ACADEMIA	Dzúrová	Dagmar	Charles University in Prague, Faculty of Science	E
		Kocourková	Jiřina	Charles University in Prague, Faculty of Science	B
		Šteffl	Michal	Charles University in Prague, Faculty of Physical Education and Sport	A
		Štěpánková	Olga	Czech Technical University in Prague, Faculty of Electrical Engineering	F
		Vacík	Antonín	Charles University Hospital in Pilsen, Institute of Forensic Medicine	C
	6 - NGOs	Ficzová	Monika	Community Care Service of Prague 6	
		Jirkovská	Blanka	Charles University in Prague, Faculty of Arts, Department of Sociology	F
		Kostelníková	Michaela	Age Management Brno, o.s.	C
		Lorman	Jan	Life 90 (NGO)	
		Vorálek	Štefan	Pro Deep, o.s.	A

Homogeneous Groups #1-6 – 36 participants
Heterogeneous Groups A-F – 26 participants


Affiliation of the Participants of the Scenario Workshop in the Czech Republic
Government
Municipality
University
Hospital
Business
NGO

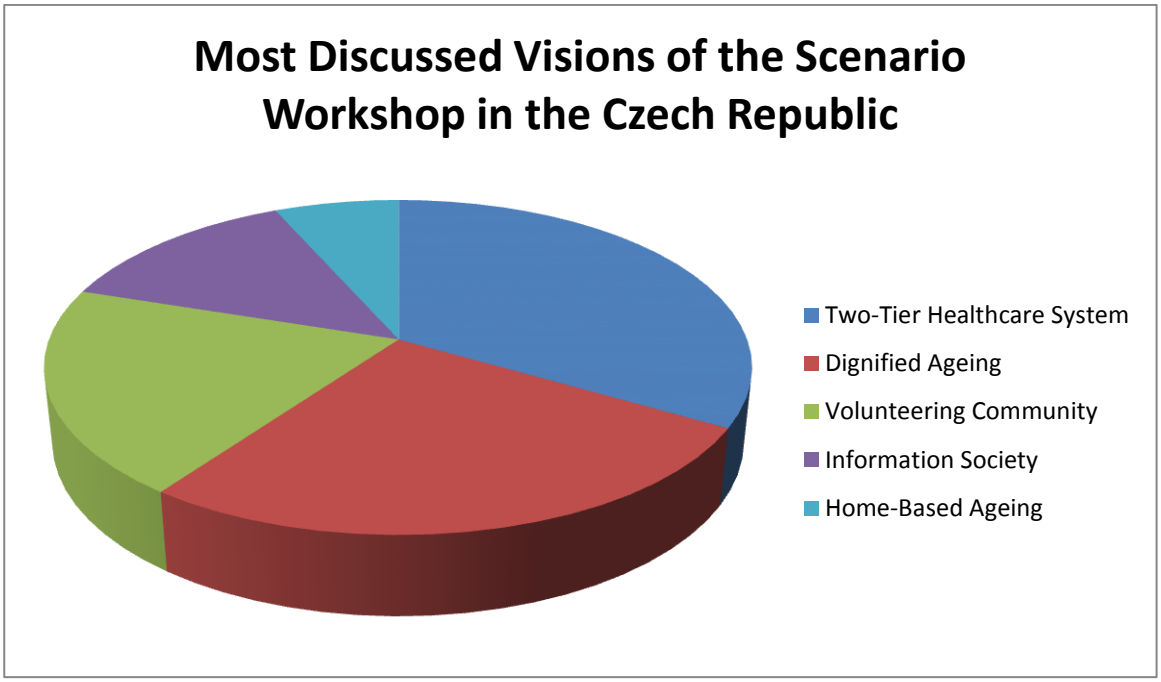

Origin of the Participants of the Scenario Workshop in the Czech Republic
Prague
Pilsen
Brno
Boskovice
Slaný

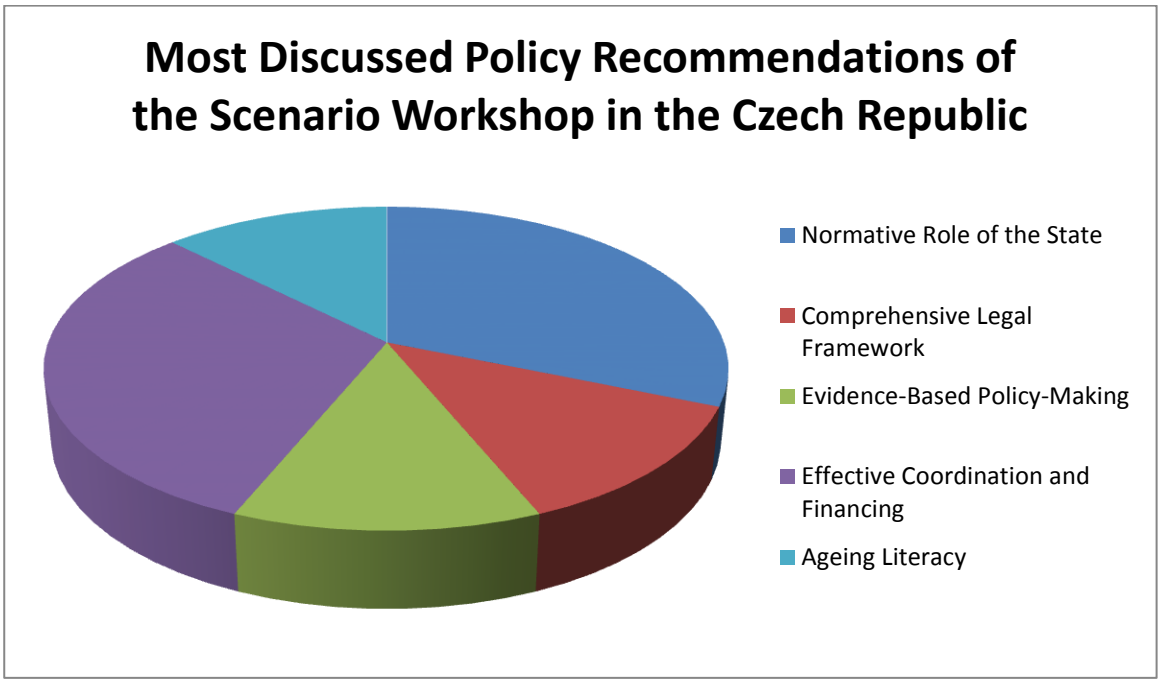

Gender of the Participants of the Scenario Workshop in the Czech Republic
Men
Women


University Degree of the Participants of the Scenario Workshop in the Czech Republic
Ph.D.
MUDr.
PhDr.
Mgr.
Ing.
Bc.
N/A

Appendix B: Summary of Visions and Policy Recommendations

Group	Visions	Recommendations
	Two-Tier Healthcare System	
A.1	Possibility to choose individualized technology as per the actual needs	Clear rules for financing to ensure adequate (European) funding
B.1	Health and social care as per the specific health condition and situation	Quantification of the actual needs – based on the evidence-based approach
C.1	State-guaranteed basic care with extra services for extra fee	Comprehensive legal framework – including standards definition
D.1	State-guaranteed basic care with an individualized approach	Uniform policy of quality ageing across the whole political spectrum
E.2	Adequate offer of care services as per the needs of seniors	Ensure adequate rehabilitation and other care services capacity
	Dignified Ageing	
A.2	Social inclusion of seniors	Better awareness of the ageing (e.g. courses for future seniors, counselling centres, etc.)
B.2	Change of the attitude towards ageing and seniors	Include a subject of ageing into primary and high school curricula
F.1	Technology as a way of social inclusion (not exclusion) of seniors	Formulate a clear and long-term national strategy for an ageing population
F.3	Ageing as a positive value	Public television should broadcast more programs about, for and with seniors
	Volunteering Community	
A.3	Non-seniors will be involved more in care of seniors	Create a methodology for volunteer work and its appropriate recognition
C.3	Socially conscious society with active links across social classes	Formulation of the educational strategies in social care
F.2	Care based on a combination of state and volunteer activities	Coordination of public-administration bodies and relevant actors at all levels
	Information Society	
C.2	People are well informed and understand the system of care	Assistive-technology providers should focus on its availability and simplicity
E.3	Coordinated and effectively communicating public administration	Maintain a clear legislative framework that provides for mandatory minimum standards
	Home-Based Ageing	
E.1	Seniors can stay at their own home as long as possible	Take into account the entire demographic system and provide support for families


Most Discussed Visions of the Scenario Workshop in the Czech Republic
Two-Tier Healthcare System
Dignified Ageing
Volunteering Community
Information Society
Home-Based Ageing


Most Discussed Policy Recommendations of the Scenario Workshop in the Czech Republic
Normative Role of the State
Comprehensive Legal Framework
Evidence-Based Policy-Making
Effective Coordination and Financing
Ageing Literacy

Appendix C: References

Blobel, B., Pharow, P., Zvarova, J., Lopez, D., editors: eHealth: Combining health telematics, telemedicine, biomedical engineering and bioinformatics to the edge. Berlin: Akademische Verlagsgesellschaft AkaGmbH 2008.

CASE Network Studies and Analyses No. 469: Conceptual Framework of the Active Ageing Policies in Employment in the Czech Republic.

Conference MEDTEL – Telematics in Health – International Conference MEDTEL – Regions and eHealth in European Union http://www.medtel.cz/ps/index.php?lg=cs

Czech Society of Medical Informatics and Scientific Information [Česká společnost zdravotnické informatiky a vědeckých informací] www.medinfo.cz

Czech Statistical Office: http://www.czso.cz/eng/redakce.nsf/i/home

eHealth Workshop 2009, Prague,

Healy, J.C.: The WHO eHealth resolution, eHealth for all by 2015? Methods of Information in Medicine, 2007 (1): 2/4.

Iakovidis, I., Wilson, P., Healy, J.C., editors: eHealth. Amsterdam: IOS Press 2004.

Institute of Sociology ASCR, 2008

Kinkorová, J.: EU projects for eHealth. eHealth days

Kocourková, J.: Demografické stárnutí české populace v evropském kontextu. Presentation on the Prague seminar on 29/4/2014.

Kučera, T., Burcin, B., 2000. Changes in Fertility and Mortality in the Czech Republic: An Attempt of Regional Demographic Analysis, New Demographic Faces of Europe, pp 371-417.

Legislative intentions of the eHealth Projects (Version 1.7) , the Ministry of Health of the Czech Republic, 2008. [Věcné záměry realizace projektů eHealth (Verze 1.7), Ministerstvo zdravotnictví České republiky, 2008.] Available only in the Czech language on: http://www.mzcr.cz/dokumenty/vecne-zamery-projektu-eHealth_959_840_1.html

Lund, 2009

Ministry of Labour and Social Affairs, 2008

Možný, 1999

Norwegian Board of Technology: Future ageing, 2009: http://teknologiradet.no/wp-content/uploads/sites/16/2013/08/Rapport-Fremtidens-alderdom-og-ny-teknologi.pdf

PACITA: Telecare Technology in Europe, 2013: http://wp6.pacitaproject.eu/wp-content/uploads/2014/02/Telecare-description-web.pdf

Population Europe: http://www.population-europe.eu/Library/Glossary.aspx

Research and development program of the Ministry of Health III. for the years 2010 – 2015. [Resortní program výzkumu a vývoje Ministerstva zdravotnictví III. na léta 2010 – 2015.] Available only in the Czech language on: http://www.mzcr.cz/Odbornik/dokumenty/resortni-program-vyzkumu-a-vyvoje-ministerstva-zdravotnictvi-iii-na-leta-kod-nt_2356_993_3.html

Rychtaříková, 2000

Sobotka, T., Zeman, K. and Kantorová, V., 2003. Demographic shifts in the Czech Republic after 1989: A second demographic transition view, European Journal of Population, 19: 249–277.

World Health Organisation: Interesting Facts about Ageing; 2011: http://www.who.int/ageing/about/facts/en/