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Executive summary

This document, which forms part of the European PACITA project, addresses the issue of ageing and technology in the Wallonia region of Belgium. It takes stock of national policies and regional practices on the issue and presents the results of the Scenario Workshop organised in April with several stakeholders from the sector. The report will be the subject of an in-depth comparative analysis with other participating member countries. The final results will be presented to representatives of the European Commission and several members of the European Parliament in October 2014 in Brussels.

This document is divided into three parts:
(1) The state of national policies and regional practices in the Wallonia region of Belgium.

(2) A presentation of criticisms and observations of scenarios suggested within the Scenario Workshop

(3) A presentation of visions and recommendations (including concrete political measures) for sectoral stakeholders for a forward-looking vision of ageing by 2025.

Introduction

Managing an ageing society is one of the major challenges identified in the European Union's Lund Declaration [Lund 2009]. The rapid increase in the number of senior citizens presents Europe with a double demographic challenge. The healthcare needs of an ageing population are increasing while, simultaneously, the size of the working population is decreasing.[1]

Recourse to technology may continue to increase, enabling society to offer healthcare solutions which respond to the needs of European populations, both in terms of quantity and quality. Our society has the choice between different health service strategies and the arrival of new technological tools in this sector. Technology holds out great hope for the future, but a number of challenges remain to be resolved and ethical dilemmas must be taken into account. How can technology best be exploited in the healthcare sector? What is acceptable and what concerns do elderly people themselves have? What options are open to political decision makers?

With a view to facilitating and encouraging forward-looking discussions and identifying strategic options, the PACITA project organised nine national and regional workshops in the following countries: Denmark, Czech Republic, Hungary, Catalonia (Spain), Norway, Wallonia (Belgium), Switzerland, Austria and Bulgaria. A Scenario Workshop is a method which aims to facilitate forward-looking discussions and to identify political alternatives in different contexts. In the context of the PACITA project, the Scenario Workshops helped stimulate discussions on the different ways of addressing the challenges of the increasing number of elderly people in various European countries, taking a range of scenarios as a starting point.

To draw attention to the potential consequences of the political choices related to ageing, participants considered three scenarios: 'One size fits all', 'Freedom of choice' and 'Community of volunteers'. These scenarios vary in terms of (1) the extent of public and private sector involvement in the provision of healthcare to older people and (2) the way in which older people and other groups in society organise themselves to meet older people's healthcare needs. In order to raise awareness of the choices which are being made currently, user statements were drafted. These were three stories about four individuals and their lives in 2025, according to each of the defined scenarios.

The scenarios and users' statements were used to stimulate discussions in the Scenario Workshops, which were organised in the various participating European countries. Each Scenario Workshop produced several visions of the type of healthcare services that stakeholders in the ageing sector could foresee for older people, as well as the political measures required to achieve this.

This report provides an overview and analysis of the results of the Scenario Workshops which were organised in the Wallonia region of Belgium on 2 April 2014 at the University of Liège. Before presenting these results, the first section recaps the regional context within which the scenarios should be considered. This section aims to identify local actors and their responsibilities in the healthcare sector, to present national and regional policies on the

[1] An ageing population as defined as a population within which the number of elderly people (65+) is increasing relative to the number of people aged between 20 and 64. http://www.population-europe.eu/Library/Glossary.aspx

subject and, finally, to define areas for development and the extent of the role that technology plays in services for older people.

The following sections present the results of the Scenario Workshop, reflecting the three phases of the day. The first few phases criticise and compare the three scenarios suggested to participants, while the third phase is a prospective phase during which the participants set out the visions which they think are desirable for the future healthcare of older people in 2025.

The results presented are the conclusions of discussions from all the groups mixed together. Notes on these discussions were collated by six reporters and analysed by the authors of this report. At a later stage, the results of nine Scenario Workshops will be collated and analysed in a single report which will be presented to regional, national and European decision makers at a 'policy conference' which will take place in Brussels in November 2014.

National context

Local stakeholders and their responsibilities in the healthcare sector

In the older people's healthcare sector, competences in Belgium are currently distributed across federated bodies and the federal government.[2]

Over the course of the various institutional reforms which have taken place in Belgium, the regions and the communities have been granted competences in terms of personal care, senior citizen policy, healthcare policy and disability policy. Since 1993, part of the competences for what is known as 'personalised' care has been transferred from the French Community of Belgium to the Walloon region and the German-speaking community. The public authority which is primarily competent for caring for people in the Walloon region is the *Direction Générale Opérationnelle des Pouvoirs Locaux, de l'Action Sociale et de la Santé (DG05)* [Executive Department for Local Authorities, Social Action and Health], including the Department for Senior Citizens and Families. The federal government, however, remains responsible for certain public activities such as social security. These competences will be examined in more detail at a later stage, as will the public authorities involved in healthcare.[3]

Personal care covers government action to support various categories of people and includes social aid, family aid and senior citizens.

First of all**, social aid** is one facet of healthcare policy because each commune in the region is obliged to organise a *Centre public d'action sociale (CPAS)*[Public Social Action Centre]. However, significant areas remain the responsibility of the federal government (and its administrative bodies, the *SPP Intégration Sociale, Lutte contre la Pauvreté, Economie Sociale et Politique des Grandes Villes* [Federal Public Service for Social Integration, Anti-Poverty, the Social Economy] and the *SPF Sécurité Sociale* [Federal Public Service for Social Security]) including certain basic regulations relating to the CPAS and the social integration allowance. In addition, some communes and provinces develop other, more local, initiatives.

Secondly, **family policy** principally operates through specific bodies which fall within the responsibility of the Communities: *the Office de la Naissance et de l'Enfance (ONE)*[Office for Births and Childhood]. Currently, the DG05 is the body responsible for such matters. In addition, the provinces and communes may play an organising role.

Thirdly, personal care also involves **senior citizen's policy** in terms of **establishments which provide housing and care for older people.**[4] The federal government (the *Office National des Pensions* [National Pensions Office] and the *SPF Sécurité Sociale*) retain responsibility for setting, granting and financing the guaranteed income for elderly people (GRAPA).

The **healthcare policy** in healthcare institutions and elsewhere (care at home, in homes for elderly people and hospitals), are also a community matter transferred to the Walloon Region

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[2] The legal basis for this distribution of competences is set out in the Constitution, Arts. 128 and 130, Art. 138, in the Special Law on Institutional Reform (LSRI) 8/08/1980, Art. 5, section 1, line II, in the Law on Institutional Reform (LRI) 31/12/1983, Art. 4, section 2 and in Decree CF 19/07/1993, Art. 3.

[3] The information presented in the following section comes from the following sites: http://www.crisp.be/wallonie/fr/pouvoirs; http://socialsante.wallonie.be; http://health.belgium.be; http://www.socialsecurity.fgov.be; http://www.mi-is.be/be-fr/start; http://www.belgium.be/fr/; http://www.onprvp.fgov.be/; www.awiph.be; www.sante.cfwb.be/.

and the German-speaking community, with the exception of university hospitals. Healthcare education and preventative medicine are another area which falls to the communities. The *Direction Générale de la Santé de la Communauté française* [Health Services for the French Community] and the *Conseil Supérieur de la Promotion de la Santé* [Higher Council for Health Promotion] are responsible for these matters. At this level, the communes and the provinces also play an organising role. However, the federal government retains responsibility in terms of legislation on hospitals, their funding and invalidity/sickness benefit through the SPF Santé Publique [Federal Public Health Service].

The Walloon region is responsible for **disability policy** for the French-speaking region, and has established the *Agence wallonne pour l'intégration des personnes handicapées (AWIPH)* [Walloon Agency for the Integration of People with Disabilities]. The federal government retains responsibility for regulations and funding of allowances, as well as for financial measures to promote the employment of people with disabilities. The provinces play an organising role in this regard.

An institutional agreement recently marked the launch of a profound change to the Belgian federal system. The second part of the sixth State reform, which ended at the start of 2014, sets out the transfer of competences from the Federal government to the Communities and the Regions. This transfer began on 1 July 2014 with, in the healthcare sector, the transfer of personal care: homogenisation of the disability assistance policy (mobility assistance and granting aid to elderly people), the policy on older people and long-term care, preventative health policy, hospital policy (including investments in medical-technical services), and health data management. Nevertheless, existing legislation remains in force until a Community or Region changes the legislation.[5]

Summary table

Authority Competence	**Walloon region**	**French community**	**German-speaking community**	**Provinces**	**Communes**	**Federal government**
Senior citizens	✓		✓			✓
Personal care	✓	✓	✓	✓	✓	✓
Health	✓	✓	✓			✓
Social security						✓
People with disabilities	✓		✓			✓

[5] http://www.wallonie.be/dossier/la-wallonie-face-la-6eme-reforme-de-letat; Palsterman Paul, 'Les aspects sociaux de l'accord de réformes institutionnelles du 11 octobre 2011', *Courrier hebdomadaire du CRISP*, 2012/2 n° 2127-2128, p. 5-54.

National policies[6]

This section identifies the various actors involved in producing healthcare policies at different levels of government in Belgium. The bodies providing these services are not only government administrations because other official bodies, the voluntary sector and the private sector are also involved in the provision of services. It is interesting to analyse the type of organisations involved in order to determine the relationship between the public and private sectors in creating policy.

The ageing population is considered as the major social challenge which governments have to address in the 21st century. Serious changes are required to adapt society to the day to day needs of older people in their homes or in care establishments. In order to respond to this demographic challenge, one measure the government has taken was the adoption of a policy note on elderly people on 29 April 2010. The government also intends to ensure the long-term integration of this objective into priorities through several legislatures.[7]

The Walloon Region provides several healthcare related services through the SPW DG05, in partnership with the *Observatoire de la Santé des Wallons (OWS)*[Walloon Health Observatory], the *Conseil Wallon de l'Action Sociale et de la Santé (CWASS)*[the Walloon Council for Social Action and Health] and the *Réseau Santé Wallon (RSW)*[Walloon Health Network]. The Walloon administration is responsible for a range of areas covering public medical-social infrastructures, social action, family assistance, outpatient and extra-hospital healthcare.

In terms of subsidies to medical-social bodies, the DG05 and, more specifically, the *Direction des Aînés* [Senior Citizens' Department], manages requests for grants submitted by public sector and voluntary (intercommunal or CPAS) bodies and monitors their compliance with relevant legislation. Medical-social bodies are residential and care establishments designed, among other things, to assist elderly people. Various residential and care structures for elderly people exist, including care homes, serviced apartments, day reception centres, health and care homes, short-stay centres, centres for acquired brain injuries, daycare centres and evening/overnight care centres. These structures provide various types of services depending on the managing body. A care home, for example, is a residential establishment in the public or private sector which is approved by the regional authority and which provides community services, daily assistance, leisure activities and some care services.

In terms of family aid and aid to the elderly, the SPW works to help families and elderly people by, in particular, supporting front line staff and independent service providers through the provision of legislative and financial resources. Thus, through its family and senior citizens' aid department, it supports elderly people in need of assistance. This consists of personal home help to encourage people to stay at home and return home, and assistance and support with daily life for isolated, elderly, disabled and ill people. These assistance and home help services employ caregivers, senior caregivers and auxiliary nurses to help older people who need help to accomplish daily tasks (such as personal hygiene, shopping, housework). The DG05 is also responsible for managing the *Agence Wallonne de lutte contre la maltraitance des personnes âgées (Respect Seniors)*[Walloon Agency to Combat Elder Abuse].

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[6] The information given in the rest of this section comes from the websites of the public institutions mentioned in the document, namely: http://socialsante.wallonie.be/, http://www.belgium.be/fr/sante, https://www.socialsecurity.be, http://www.onprvp.fgov.be , http://www.belgium.be/fr/famille/aide_sociale/seniors, http://www.riziv.fgov.be/homefr.htm, http://www.sante.cfwb.be, http://socialsecurity.fgov.be/fr.

[7] On this subject, see the Regional Political Declaration by the Walloon Government for the 2009-2014 legislatures. In addition, other protocols have been concluded between the various authorities in the country, such as the Memorandum of Understanding No. 3 of 13 June 2006 concluded between the Federal government and the federated bodies, on healthcare policy towards elderly people.

In the healthcare field, the SPW conducts inspections of hospitals in the region as well as approving hospitals, without which they are unable to provide care. In the French-speaking community, healthcare policy is largely focussed on health promotion, preventative medicine programmes, vaccination policy, and social-health data. The sixth State reform had consequences for healthcare policy because, since 1 July 2014, the competences transferred to the Walloon Region and the *Commission Communautaire Française (Cocof)*[French Community Commission] now fall within their responsibility. In practical terms, from 1 January 2015, the date at which responsibility and the budget were effectively transferred, the *Direction Générale de la Santé du Ministère de la Communauté Française* [Ministry for the French Community Health Service] will no longer exist.

Similarly to the health policy, competences exercised at the regional level are closely linked to certain competences which have remained federal, such as regulations on health and invalidity insurance as well as certain standards for approving healthcare establishments.

The Federal government currently still has responsibility for social security and health. In Belgium, social security covers retirement and survivors' pensions as well as residual schemes offering guaranteed income to elderly people (GRAPA) and allocations to people with disabilities. From the age of 65, elderly people with reduced autonomy have the right to financial assistance. This elderly people's allowance forms part of the allowances for people with disabilities. The *SPF Sécurity Sociale* is directly responsible for this policy.

On this subject, the *Institut National d'Assurance Maladie-Invalidité (INAMI)*[National Institute for Health and Invalidity Insurance] plays a crucial role in healthcare and incapacity benefit, as the federal agency responsible for the health insurance fund. It organises, manages and controls compulsory healthcare insurance in Belgium. This public social security institution develops the rules for refunding healthcare provisions and medications. The INAMI controls both private healthcare funds and healthcare professionals. The INAMI works in partnership with various stakeholders in the healthcare insurance and compensation sector. Its partners include mutual insurance companies, representatives of healthcare professionals, independent healthcare providers (doctors, physical therapists, pharmacists, etc.), medical-social institutions, and trade union and employers' representatives.

Of INAMI's partners, the mutual insurance companies play a crucial role in the Belgian healthcare system. Several types of insurance bodies are open to citizens wishing to benefit from compulsory insurance services, healthcare and compensation.[8] Mutual insurance companies contribute towards their members' healthcare costs and provide compensation in the event of invalidity caused by illness.

Within the *SPF Santé Publique*, *Sécurité de la Chaine Alimentaire et Environnement* [Federal Public Service for public health, food chain safety and the environment]*, the Cellule Soins Chroniques, Soins aux Personnes Âgées et Soins Palliatifs* [Chronic care, care for the elderly and palliative care unit] implements federal policy in partnership with the communities and regions. Its competences relate to organising, programming, accreditation standards and improving the funding of existing care structures, the development of alternative arrangements for providing and dispensing care. A national inquiry on the operation of the care services for elderly people has been ongoing since 1996. Covering care homes and daycare centres, the inquiry aims to improve the performance of the healthcare policy and the relevant institutions for elderly people.

[8] There are three different options when it comes to mutual insurance: to join a private national mutual insurance fund (Alliance Nationale des Mutualités Chrétiennes; Union Nationale des Mutualités Socialistes; Mutualités Libérales; Union Nationale des Mutualités Libres); to join a regional office of the Caisse Auxiliaire d'Assurance Maladie Invalidité (CAAMI); to join the Caise des Soins de Santé de la Société Nationale des Chemins de Fer Belges (SNCB). See http://inami.fgov.be/homefr.htm

In addition, the federal authorities have a certain number of coordinating bodies which provide opinions on healthcare policy in Belgium, including the *Conférence Interministérielle Santé Publique* [Interministerial Public Health Conference] which ensures coordination between the various government levels.[9] Consultative bodies also exist in the sector such as the *Conseil Supérieur de la Santé (CSS)*[Higher Council for Health] and the Conseil *Consultatif Fédéral des Aînés (CCFA)*[Consultative Federal Council for Older People].

Finally, public policies may also emanate from the communes through the CPAS, which ensures the provision of a certain number of social services. Among the range of services offered, elderly people (both dependent and independent) can benefit from financial and medical assistance, home help, or admission to various categories of healthcare institutions. In addition to the range of regional services, day assistance services may be offered by the provinces, private bodies or mutual insurance funds. It is true to say that an extensive network of local and regional social assistance centres providing aid and care at home exists.

Technological developments and legislation

The Walloon region is still at the start of the process of developing fully fledged policies on tele-assistance and tele-medicine. In order to address the ageing population, a solid policy framework integrating technological development is still currently lacking. It cannot be said that regional policies relating to tele-assistance and tele-medicine are currently being implemented on the regional level. It appears, in fact, that this issue is not a priority for the Walloon government, which has not yet really defined its strategy in terms of e-health, although it should do so shortly.

Besides the regional level, the federal government remains competent for certain areas of public activity. In terms of public health, a national policy on e-health has been defined. It appears that the transfer of competences will provide more competences in terms of health for the regions in terms of tele-assistance and tele-medicine and may eventually lead to real regional policies on these subjects.

Due to this experimental phase in which the Walloon region finds itself, we have identified three relevant policies relating to tele-medicine and tele-assistance.

First of all, the *e-Health Action Plan 2013-2018* is the most developed policy on e-health.[10] The various Ministries (federal, communal and regional) responsible for healthcare policy met on 29 April 2013 during the Interministerial Conference on Public Health, to approve the 2013-2018 action plan on computerising healthcare. This action plan resulted from a round table in 2012 which brought together more than 300 stakeholders and the e-Health Platform originally created by the law of 21 August 2008 relating to the creation and organisation of the e-Health Platform. The objective of this policy is to establish an electronic patient hospital file through the generalised use of e-healthcare services to retain and exchange patient file information on healthcare and health insurance. The e-Health law thus made it compulsory to use a social security identification number (NISS), by means of which every Belgian resident could be identified. This was a fundamental step forward for patients, healthcare providers

[9] The following coordinating bodies are active in the healthcare sector: The National Council for Hospital Facilities (HTML), the Multiparty Structure (HTML), the Joint Commission (HTML), the Commissions (HTML) – Telematics, the Federal Platforms (HTML): Palliative care, Psychiatry, the Doctors' Colleges (HTML), the Committees (HTML), the Planning Committee (HTML).

[10] This public policy is not specifically focussed upon elderly people. Other more general initiatives exist to promote the computerisation of healthcare such as the MHD (Minimum Hospital Data), the MCD (Minimum Clinical Data, the MND (Minimum Nursing Data), the Portahealth project and the eHosp project.

and social security stakeholders. This policy is destined to become the single point of access to available computerised data and a means of modernising healthcare through the coordinated development of the telecommunications sector and information technology.[11]

Secondly, the BelRai project, Belgium Resident Assessment Instrument, began in 2006 in order to respond to the need to find a unique and highly-performing tool on the basis of which a health plan could be adapted to various healthcare contexts (at home, in residential care, in hospital). Since then, various drafts of the project have developed. This tool to evaluate the individual needs of the patient, the RAI, is currently in the test phase. Eventually, the objective of this international tool will be to increase the quality of care for elderly people and to encourage the use of standardised evaluation methods. This tele-medicine technology may be used to quantify disease and assess the effectiveness of care. The InterRAI Acute Care project provided the opportunity of using the RAI in geriatric departments and general wards, within the context of implementing the geriatric care programme. The Walloon Ministry of Health recently marked the region's commitment to the RAI project by signing the e-Health Action Plan 2013-2018.[12]

Thirdly, the *Walloon Code for Social Action and Health*, which has been in force since 31 December 2011, makes reference to tele-assistance mechanisms. The Code deals with financial assistance (grants) for elderly people who can obtain remote assistance using a technological device. The grant is awarded to anyone over the age of 60 with less than 66% of their capacities who lives alone and whose annual gross income is less than the amount set by government.

Local variations

This section describes the tele-care and tele-medicine technologies which are currently being used in the Walloon market. The Walloon region is in an experimental phase because, due to the lack of real policy priorities, only local pilot projects and private projects have developed. Among the public stakeholders, hospitals, communes, rest homes and care homes occasionally, and locally, use new technologies. These projects are consequently isolated because a clear policy of regional coordination is yet to be decided by the political authorities.

Monitoring systems and tele-assistance in the form of alarms are the technologies which are currently the most developed by service providers in the region because insurance companies offer to reimburse these devices. These small devices may be worn on the body and in the event of an emergency the person can press the emergency button to call for help. *Vitatel, CISS and Tele-secours* offer this type of service.[13]

Other private initiatives have also developed. Since 1994, MEDIBRIDGE has been developing software for healthcare organisations and providers. It enables the exchange of information and secure consultation of prescribed medications, test results and patient data. The AMAC organisation offers automatic monitoring of elderly people's daily activities through sensors. OLDES offers elderly people adapted versions of modern communication technology such as VoIP (voice over internet protocol) to monitor their health. The e-Patch service is an electronic detector to geolocalise and detect when elderly people fall. The *ROGER* project (Realistic Observation in Game and Experiences in Rehabilitation) currently

[11] http://www.rtreh.be
[12] Presentation J. Collard, Evaluation de l'opportunité de l'utilisation de l'interRAI Acute Care dans les services de gériatries dans le cadre de l'implémentation du programme de soins gériatriques, University of Liège, Centrum voor Ziekenhuis-en Verplegingswetenschap. https://www.ehealth.fgov.be/fr/application/applications/BELRAI.html.
[13] http://www.vitatel.be/, http://www.gls-sisd.be/presentation/fiches/cis.php, http://www.tele-secours.be/.

led by the ERASME Hospital and the Fishing Cactus company (Microsoft xbox Kinect) is looking at therapeutic rehabilitation of brain injuries in people with cognitive difficulties, attention deficit disorders, memory or organisational problems due, for example, to injury, stroke or illnesses such as Alzheimer's disease.[14]

[14] http://www.medibridge.be/fr, https://www.cetic.be/AMACS, https://www.cetic.be/OLDES, https://www.cetic.be/e-Patch-1857.

Scenario Workshop in the Walloon Region of Belgium

Preparations

A team of four people worked on the entire process of preparing the Scenario Workshop. Shortly before the day of the workshop, Pierre Delvenne coordinated the training of 12 other SPIRAL researchers who participated in the day, either as facilitators or as reporters.

Recruitment and participation process

A database of stakeholders who were active in the ageing population sector was constructed on the basis of internet research, snowball sampling through participants' networks, internet communication within the University of Liège, and access to existing lists, such as those containing the contact details of all directors of nursing homes in the Walloon region. When necessary, certain participants were recruited by telephone. The database was created by three team members: Pierre Delvenne, Benedikt Rosskamp and Céline Parotte.

The aim was to recruit between 40 and 50 participants for the Scenario Workshop and to ensure that they effectively represented different areas linked to the theme of ageing: R&D technologies, scientists, insurance companies, nursing home directors, home help centres, directors or employees of public social aid centres, active members of civil society organisations, nurses and doctors, representatives of public authorities and Ministerial cabinets.

These objectives were met and 43 participants were recruited (Annex A). These participants were split into six diverse groups of seven or eight people in each group. Given the number of cancellations, reception staff at the venue adjusted the groups so that they would be as diverse as possible, although this was a difficult task. As a result, some groups had between four and seven participants.

Practical organisation of the Scenario Workshop

The Scenario Workshop was held over one day at the Château de Colonster, on Wednesday 2 April 2014, at the University of Liège Sart Tilman campus.

To facilitate the day and discussions, all participants received a preparatory email with a document explaining the Scenario Workshop method, the PACITA project and setting out the three proposed scenarios.

On the day of the Scenario Workshop, participants were invited to arrive from 8.45am. Upon arrival, everyone received a name badge and a folder containing the document which had previously been sent by email, a full list of participants, a sheet with the various groups, a notebook and a pen. Participants were asked to fill in a form in order to have their travel expenses refunded.

Three rooms were available to the participants for the discussions. Each group was provided with a flip chart, a set of pens and coloured post-it notes.

The day finished around 4.30 p.m. after the concluding remarks. The day was split into three sections. The first section aimed to collate participants' general reactions about the scenarios. The second section aimed to compare the scenarios to participants' knowledge of

reality. The third and last section established the participants' future visions on the theme of ageing.

Detailed programme of the day

8.45 a.m. - 9.00 a.m.	Participant registration
9.00 a.m. - 9.15 a.m.	Welcome and introduction
9.15 a.m. - 9.45 a.m.	Short presentation of the scenarios
9.45 a.m.-10.30 a.m.	Phase 1: *General reactions to the scenarios*
10.30 a.m.-10.45 a.m.	Coffee break
10.45 a.m. -11.45 a.m.	Phase 2: *How realistic are scenarios 1, 2 and 3?*
11.45 a.m. -12.45 p.m.	Lunch break
12.45 p.m. -1.30 p.m.	Plenary session – presentation of the results of Phase 2
1.30 p.m. – 2.45 p.m.	*Phase 3: Formulating participants' visions*
2.45 p.m. – 3.00 p.m.	Coffee break
3.00 p.m. – 3.45 p.m.	Plenary session – presentation of the results of Phase 3
3.45 p.m. – 4.00 p.m.	Conclusions

Phase I and II: Responding to and criticising the scenarios

Scenario 1: One size fits all

General responses to the scenario

Is the future vision of Scenario 1 realistic or probable?

YES

According to some participants, this scenario is probable because in the Walloon region there is a tendency towards collectivism and helping people in the community without distinction.

Some believe that we are in a context where financial resources will be limited. In this context, there is a need to find something which fits everyone. The crisis is two-fold: economic and employment-related. The lack of labour force in the medical and personal care sectors also make this scenario possible.

Finally, others mentioned that technology has made enormous progress and that the cost of these services could be borne by the community, which is why it is realistic to foresee a greater role for the communes. Moreover, an increasing number of elderly people want to remain in their own homes, which technology already helps them to do (for example a GPS watch) and will increasingly enable this to be the case. However, these hands-free kits should be combined with external aid and care should be taken to adapt accommodation appropriately.

NO

According to other participants, the scenario is not probable given the particular political context in the Walloon region, the care which the scenario addresses, technological progress which is yet to be made, the acute monitoring which it implies and, finally, the qualified labour force which is required, despite the paucity of supply.

Principally, some believe that in the Walloon context there is a certain political balance to be respected and that it is not possible to draw up a single political solution. But several participants noted that the public authorities are not yet ready to address the ageing population and the task is often delegated to the private sector. These participants regard this as a demonstration of the public sector's current lack of involvement in this sector. This scenario has become impossible given the current budgetary context.

Others continue: supporting the cost and training of staff which will carry out the monitoring, finding a qualified labour supply, and adapting the education sector to meet these needs makes this scenario unrealistic.

According to some, the care itself poses a problem: it will be specialist rather than primary care which will be affected first.

From a technological point of view, others believe that the progress which is believed to have been made in the 2000s has not actually taken place, and it is unlikely that it will have in the fifteen or so years to come.

For several participants, it is also unlikely that people will agree to be monitored by technology. The communes will not have the human and financial means required to best manage these new skills, and in any case, they will never be ready in time. In fifteen years, people will not be ready in terms of technology and will not know how to use it.

Is Scenario 1 desirable?

YES

Several participants think that this scenario is desirable for several reasons.

First of all, they consider it to be egalitarian; everyone can benefit from this universal system of coverage. Consequently, it is considered as interesting in terms of solidarity on the regional level: 'Everyone needs to contribute to this, even though not everyone agrees with it'.

Finally, it is desirable from a democratic point of view. In means that profit is no longer the most important issue.

Moreover, these participants believe that it is for the public sector to address the issues of ageing and cognitive problems.

Finally, others put forward an authoritarian argument: 'In any case, there are no alternatives'.

NO

Five reasons were identified by participants who considered this scenario undesirable.

For them, each case is unique and applying a one-size-fits-all solution is undesirable. This risks increasing dependency on technology and thus 'accentuating the stereotype of the incapable old person'.

According to these participants, the scenario is also too impersonal, directive and not 'human' enough.

Moreover, some questioned who would be responsible for creating the kits and who would not be covered by them:

> 'Who will decide what will be in the kit?' and 'Although people who are disoriented form the biggest issue, this approach does not address them."

The scenario, according to others, poses ethical problems such as, for example, respect for private life.

Finally, this scenario denies the skills acquired by the private sector and 'it would be a shame to ignore these, particularly because the politicisation of the ageing sector means that scenarios cannot be developed transparently.' The public sector is already starting to withdraw from this area. However, the public monopoly raises the question of funding, which cannot be permitted in the current context of economic restrictions.

<u>Positive responses to Scenario 1</u>

Among the positive responses to Scenario 1 are the following arguments:

First of all, it takes into account e-learning and training care staff. This scenario also devotes a significant amount of attention to prevention. Everyone can access a minimum level of care at an equitable cost.

Secondly, the fact that this scenario also makes solidarity and social cohesion possible: 'If public authorities do not take this decision, everyone will go in a different direction.'

Finally, older people may remain in their own homes in a safe environment using technology which measures several parameters, and this applies to the entire population.

Negative responses to Scenario 1

One of the main negative responses to Scenario 1 is that prevention may lead to the opposite of what is desired. The counterpart to security is the constant monitoring of elderly people and the associated loss of liberty.

Second, the cost for the public sector is considered as too high, and participants believe that need has not been precisely evaluated and risks wasting more resources. According to these participants, the communes have already too many challenges to address to take on the role that the scenario foresees for them.

Third, according to some participants, the fact that there is less human contact in this scenario increases the risk of isolation, even when care workers play a monitoring role. The scenario reduces spontaneous interpersonal relationships. Consequently, local knowledge exchange networks will disappear.

Fourth, the use of technology appears difficult in the event of dementia: machines don't try to understand and technology cannot be adapted to real situations, thus increasing the risk of people suffering from dementia becoming isolated.

Fifth, the scenario does not promote participative dynamics.

Sixth, technology is considered as intrusive and leads to constant monitoring of individuals.

Seventh, there is a lack of first line medical support: doctors and medical staff are removed from the equation.

Eighth, the slowness and inability of the public sector to adapt; this scenario, which anticipates one-size-fits-all health kits shows applies the same solutions to all individuals. The resources implemented are not sufficiently refined and are disproportionate to the goals. Standardisation is considered in this case as an easy solution.

Finally, this scenario leaves no room for a positive vision of ageing: 'it says that you are going to be ill and you are going to cost money so the State will make you up a kit that needs to be financed'. This type of statement, for some, does not help generate a positive image of ageing, which is considered primarily as a problem: 'Thankfully, however, it is possible to age well.'

Ethical and moral dilemmas in Scenario 1

The participants identify two main ethical and moral dilemmas in this scenario.

Standardisation >< individualisation of care.

The first is that which opposes standardisation to the individualisation of care. Standardisation provides easier access to care and reflects a more united and less unequal society, but individuals all have different needs which require more targeted treatment.

Technology to liberate >< to control individuals.

The balance between these must be positive in terms of our use of technology. Technology must make older people more autonomous without this autonomy being too damaging to their individual freedoms (right to private life).

Scenario 2: Freedom of choice

General responses to Scenario 2

Is the future vision of Scenario 2 realistic or probable?

YES

Some participants think that this scenario is probable from the point of view that public investment is lower, that there is a greater role for the commune and there is financial pressure upon the commune. Moreover, 'the private sector already plays a significant role, either alone or in partnership with the public sector'. According to these participants, these characteristics are fairly close to the current reality.

It is often the acute presence of the private sector, raised by participants, which justifies the realistic or probable nature of this scenario:

> 'Unfortunately yes, because liberalism is taking over society'.
> 'The dynamic of the private sector is more intense than that of the public. This is already a reality, we can see it in the evolution of private groups which already provide a large majority of care to elderly people.'

Finally, for some, this plan is appropriate because it will resolve the problem of reducing budgets in the public sector while social security budgets will rise considerably in the future.

NO

Participants felt that this scenario is also unrealistic or unlikely because it is difficult to envisage how the commune can check the appropriateness of the care administered. On the other hand, management at communal level is not compatible with the liberalisation of care and the role devolved to the communes appears too significant.

Other participants also mention the unsuitability to the Walloon context.

> 'We are talking about the Walloon region. Implementing such a scenario requires political and social agreement, not to mention resources, which do not enable us to move in this direction. Walloon society remains united. '

However, it is possible that in such a scenario, the *Institut National d'Assurances Maladie Invalidité* (INAMI) would perhaps continue to finance certain things.

For others, this scenario is quite simply politically, socially and ethically unacceptable. It is a liberal project that some participants do not wish to see because some communes will be

able to draft a plan for elderly people while others will do nothing, because they won't have the same resources. This scenario would lead to an unequal healthcare system in which the communes will give up on certain categories of people. In this case, citizens will have no other option than to chose their commune based on what is available (as is the case for the *Centres Publics d'Action Sociale* - CPAS). Some communes will be deserted.

Moreover, several participants believe that this project to is focussed on profit.

Finally, several questions remain such as 'How should differences in income between elderly people be handled? What about those who are left by the wayside? '

Is Scenario 2 desirable?

YES

Several arguments were put forward by participants who felt that this scenario was desirable.

First of all, it leaves freedom of choice and everyone can use the resources they have depending on their ability. This scenario adapts to need and to changes in society.

Finally, competition between care providers would lead to improvements in the provision of care and services.

This system is more flexible. There is less control and it is more targeted, human and ethical [than Scenario 1], if the resources are in place.

Finally, others believe that if we believe in the virtues of free-competition, and if quality assurance mechanisms are established (ISO standards etc.), 'we are well on the way to quality assuring healthcare.'

NO

Some participants feel this scenario is undesirable for several reasons.

This project is too liberal. It reinforces social inequalities, it reinforces regional inequalities and leads to a two-speed healthcare system, based on resources, not on need.

Subsequently, because healthcare and financial incentives should not be connected: currently, nursing homes should not be improving care in order to receive money.
Control over the private sector is not always easy to establish and the market does not allow resources to be allocated correctly.

Moreover, this poses a risk of developing 'gadget technologies' which yield great returns to the industry, but not to the individual.

Moreover, this leads to a dependency relationship and a deterioration in the relationship between the 'ill' person and his or her carers.

Others believe that if everything is focussed on technology, there is a risk of becoming too dependent upon it.

Finally, 'who decides for people who are not autonomous?'

Positive responses to Scenario 2

According to several participants, this scenario is positive because it encourages the spirit of enterprise and freedom of choice. The system of free competition encourages creativity and innovation and encourages modernisation by turning to the private sector to support the public sector. It would have the effect of encouraging care providers to increase the quality and diversity of their services.

This scenario also encourages the individualisation of care and less wastage.

The assistance budget (sum allocated to people for their needs) is something positive because it enables more flexibility depending on older peoples' needs. This guarantees a basic rate which is accessible to all and the possibility of choosing depending on specific need.

Finally, as the result of technology, older peoples' individual freedoms and autonomy are better respected. Passive surveillance guarantees transparency and safety.

Negative responses to Scenario 2

Several negative elements were identified in this scenario.

First of all, according to the participants, it reinforces inequalities. There is a gap between the law and its application in practice. It will lead to some geographical areas being even more disadvantaged:

> 'there will be regional inequalities: we will see a lack of places where it is cheaper, and too many places where it is more expensive ...'

Participants then questioned the type of control possible in this scenario and the role of public authorities;

> 'there will be numerous initiatives and no arbitration or centralisation of the reference framework for the ageing population. '
> 'Are public authorities capable of retaining the parameters of this liberalisation? Finally, who will prescribe the technological devices to older people? How will health professionals be trained? We run the risk of seeing doctors prescribing technology as a result of commercial interest.'

Participants consider that it is 'fragile individuals who risk losing their way and being left along the wayside'.
According to some, job losses are likely.

This scenario was also seen in a negative light by several participants because it creates a strong dependency on technology. Consumerist logic is pushed to the extreme, futile items are sold to make profit and it will be difficult for older people to make the right choices (in addition, there is a risk of playing upon the vulnerability of older people). This could lead to a two-speed society and the emergence of 'own brands' and low-cost care homes. In this context, who guarantees quality?

These participants believe that not everyone is capable of managing and making choices (for example, confused patients). Choices may also lead to anxiety, adding another pressure upon the older person. There is also a risk of making the family, who need to make choices

with serious consequences, feel guilty. Moreover, there are financial constraints which may play a role at the cost of the older person's wellbeing.

Others believe that everything depends on the ruling political power. According to these participants, if the ruing party is one with liberal tendencies, it risks being more problematic, 'because the competition aspect will always win out'.

For these participants, there is a need to remain attentive to abuse as the result of too great a degree of liberalisation. This may ultimately have the inverse effect. As one participant explained, the public sector's loss of social control will lead to a new and more diffuse social control, through the use of technology. When liberties are extolled too highly, it leads to a pendulum system where society organises more social control through the opportunities made possible by technology. This poses safety risks and risks of an authoritarian nature.

Ethical and moral dilemmas in Scenario 2

Four ethical and moral dilemmas were identified in this scenario.

Technology >< human contact

Although some participants explained that technology costs less than human beings and provided an outlook on the world, they stressed that human contact remains important. It is therefore necessary to find a compromise. For example, when robo-seals are caressed by older people who believe them to be real, this raises a series of questions on the intermediary role of technology in the construction of social relationships. The socialisation which technology enables is not always that which older people need in order to feel less alone.

Surveillance >< private life

Participants highlighted the tensions related to the use of technology: on the one hand, being monitored for one's own safety and, on the other, maintaining one's private life. For example, children could monitor their parents and make decisions on their behalf. Some participants explained that it is important to recall that everyone has a right to a private life and there is a need to ensure that technology does not transgress all boundaries.

Liberalisation >< nationalisation of care

This dilemma highlights the tension between liberalisation and nationalisation of healthcare to ensure the patient's wellbeing. In this scenario, some believe that there we are moving from a form of public sector dependency to a strong dependency upon the private sector. As illustrated by several foreign case studies, the risk is greater with liberalisation that financial considerations will win out over patient wellbeing.

Accessibility of technology >< informed healthcare choices

The final dilemma highlights the tension between easier access to self-prescription thanks to new technology and the ability (or not) to make informed choices about one's own care. For example, new technologies such as the Internet often lead patients to seek out information for themselves. This may lead to self-prescription and, where clear regulations are lacking, to commercial healthcare-related sites dominating. In the case of demented or confused

patients, they should have access to new technology but should not make informed choices without an intermediary (health professionals, family, etc.).

Scenario 3: Volunteering community

General responses to Scenario 3

Is the future vision of Scenario 3 realistic or probable?

YES

For some, it is necessary to share resources and accommodation and this scenario proposes less onerous solutions. The financial crisis led to a return towards the social economy and the process of pooling resources and services. Moreover, liberalisation is already underway. It is interesting, according to these participants, to imagine replacing employees with volunteers.

NO

Some participants consider this solution to be unrealistic because volunteering is unlikely: there needs to be a desire to help. According to these participants, volunteers are not as reliable and available as paid workers. The same can be said of society:

> 'There are not enough people in our individualist and consumerist society who are oriented towards others to achieve this scenario, this is not our mentality. People are egotistical, everything is about money, while volunteering is utopian. As a result, there will never be enough volunteers. '

This vision is also considered to be too idyllic. This idealism is also reflected in the role of the communes.
For others, this scenario falls into the stereotype of ageism: there is a need to show that ageing can also be something positive, so that people want to grow old but also to look after older people.

According to these participants, it is also difficult to establish such a system through legislation, although our culture does accord a very important place to social law.

Participants also noted that this scenario sets out responsibilities without these people being able to take them on.

Finally, as was generally the case with the preceding scenarios, several questions remain unanswered:

> 'If volunteers are interchangeable, we lose the human aspect. And who is going to supervise the volunteers? '

> 'What status do volunteers and informal carers have? What recognition? What 'remuneration'?

Is Scenario 3 desirable?

YES

According to these participants, this scenario is desirable because:

First, preventative healthcare means we can expect to see more active senior citizens and keep them in good health. Older people retain a certain freedom and social relationships. They also find new sense of recognition, and play an important and gratifying role in society.

Quality standards are also established.

Moreover, this scenario creates links with family, neighbours, friends, etc. 'We would pay more attention to one another if we felt that more attention will also be paid to us in return. '

In addition, the financial cost will be lower [than in the other scenarios].
In this specific case, society is more united and equitable and participation is a source of cohesion.

Finally, for some, it is desirable for the commune to organise this.

NO

According to other participants, this scenario is not desirable because the status and competences of volunteers are not clear.

> 'How can we ensure that volunteers have the required skills? Training needs to be strengthened for volunteers. '
>
> 'What status should volunteers have? '
>
> 'Volunteers' workloads and responsibilities are very significant and they must be recognised; but at what cost? '
>
> 'Do we have an idea of the number of volunteers who would agree to be involved in this type of system? '

Finally, some believe that the system must complement any private system of caring for older people.

How can the risk of control be managed? The scenario does not anticipate any solution to the problems of respect for private life. '

Positive responses to Scenario 3

First of all, many believed that this scenario enables a high standard of care.

It also makes older people participate, keeps them active, uses their experience and supports local initiatives. It stresses the importance of social relationships, with a view to encouraging them. This is important because older people who have little stimulation often see their state of health deteriorate. Participants believe that social relationships are synonymous with well-being.

This scenario also gives a positive image of older people in the population. The stereotype of ageism is, consequently, less pronounced.

It encourages human contact, community support, economic access is easier and safety is increased because 'the more aware we are of others, the more attention we pay' (e.g. reduction in theft). In this context, even vulnerable people are better taken into account.

For several participants, information and communication technology (ICT) is presented in a balanced way. Technology is there to help, is not too invasive and does not necessarily reduce human contact. In this scenario, technology is not necessarily opposed to social relationships: technology can be used to create social relationships (smart-TV, interactive digital interfaces) but not to replace them.

Participants also believe that the public/private partnership has been tried and tested and each sector has a well-defined role. In this scenario, participants consider that competition between different types of bodies is not a bad thing and means that the best can be taken from both sectors.

In sum, one participant concluded: 'Ideally, this is a world of which we all dream. Isolation is reduced and the active participation of all is increased. It is a win-win situation. Intergenerational support is promoted and solidarity and quality of life in general improve. 'The concept of volunteering is 'great' but, practically, two questions remain: how can it be promoted and valued?

Negative responses to Scenario 3

Several negative responses to this scenario can be formulated as questions. It should also be noted that because several questions remain without answers, this scenario is not always considered desirable.

The lack of qualification and supervision of volunteers is a problem. Volunteers are not trained, do not always have the right tools and may sometimes risk doing more harm than good. Some participants explained that volunteering means working without an employment contract and, in this case, questions over responsibility and safety are very problematic.

This also poses the question of the role of healthcare professionals in this type of scenario. Participants asked questions such as: What is the role of healthcare professionals, whose skills are no longer sufficiently respected? According to them, it is sometimes dangerous to give complex tasks to volunteers. There is a risk of a possible deterioration in the quality of services. Moreover, there is a problem of interference between the skills of those who are currently qualified and those of future volunteers. What is the best way to spread these skills?

Public/private partnerships also post the question of the communes' ability in this context:

> 'How will the communes manage everything, and coordinate the provision of services? '
>
> 'Is it really cheaper? This camouflages the public sector's lack of engagement and economic disadvantages. '
>
> 'What are the best technological resources to put into place? '

Others criticise the very concept of giving in order to receive. They expressed concern about the case of people with dementia, or those who are isolated. These people risk receiving less than others because they can't give as much.

Some participants note that intervention only takes place when a crisis occurs. According to them, older people are not always able to identify a problem themselves.

Finally, the concept of community is criticised for the detrimental effects which it can produce such as: 'the risk of withdrawal from society, villages of older people, ghettoisation'. On the other hand, what happens to people who are extremely isolated (especially for those in rural communities)? And for people whose close neighbours are not well-meaning (this scenario may place them in danger)?

Ethical and moral dilemmas in Scenario 3

Social cohesion >< social justice

For many participants, this scenario is considered as fairly idealistic (social cohesion and solidarity) but it also runs the risk of giving rise to serious injustices. According to these participants, not everyone is equal in the fabric of our society. Between the fictional characters of the couple and Oscar, for example, there is a great difference. Some people are educated and have a good social network, while others find it more difficult to integrate into a social support network. This is also the case of technology: participants believe that 'graduates will be more at ease with technology than bus drivers'. These unfair risks represent in some way a return to the state of nature. In this context, participants believe that it is the public sector which should shoulder its responsibilities. This is primarily about the local social fabric. Older people who are well integrated into society have better resources in terms of social support, than isolated people.

Giving and receiving >< being no longer capable of giving but needing to receive

The win-win principle is under pressure. It presents both advantages and disadvantages for people who are incapable of providing a service in return. What can people do when they are not capable of returning what they receive? According to the participants, there is an imbalance between those who are capable of working with the win-win situation and those who are not. How can we identify if someone is capable or not? Upon what basis is this distinction made? How can we create equivalence systems for services rendered?

Quality social relationships >< quality of care

This dilemma highlights the tension between the role of volunteers and healthcare professionals. On the one hand, social relationships improve (with volunteers who are present 24 hours a day), but on the other, there is a risk of reducing the quality of support: 'how are volunteers trained? Can they respond to all types of request?'. Volunteers need to be prepared so they are capable. To do so, training will have to be organised for volunteers.

Respect for private life >< volunteer's sphere of intervention

Respect for private life is important for participants. Respect for private life causes tension with the work of the volunteers. How is it decided whether an intervention is necessary or not? How relevant is the intervention? Limits need to be clearly set. Finally, how is medical confidentiality maintained when it is no longer healthcare professionals (bound by medical confidentiality) who are intervening?

General responses to the scenarios - summary

Each of the scenarios presented above gave risk to a number of comments and remarks. They all presented advantages and disadvantages.

Thus the 'one size fits all' scenario is desirable in that it means that everyone can benefit from care and no one is left by the wayside. However, this standardisation of care may be inadequate in some cases.

The 'freedom of choice' scenario highlights the importance, according to participants, of freedom of choice: Everyone needs to choose the care and technology adapted to their needs. If competition within the private sector spreads, the public/private sectors may lead to improvements in the provision of care to older people, but may also be inconvenient when this logic is pushed to the extreme.

The third and final scenario is often qualified as 'idealistic', but its role in practice is often questioned: can society promote volunteering?

Independently of the scenario in question, a series of questions were asked: What is the role of technology? Participants were clear: technology must be a support and not a substitute for human contact. It is also necessary to find a balance between surveillance, on the one hand, and the safety of the older person on the other. What is the role of healthcare professionals in this type of scenario? Often, participants stressed the need for training and information for these professionals who have to address human and financial resources but often have to juggle new technology and acute demand for care services from the ageing population. According to participants, these practitioners act as intermediaries, as a relay point between technology and older people, between the care to be provided and the interventions to conduct. The question of the role of the volunteer raised as many questions as challenges: volunteers should not replace professionals, but support them, the issue of medical confidentiality, their ability to conduct certain tasks, supervision, their skills, and their training are some of the many thing that remain to be resolved.

Finally, many participants drew attention to the very definition of the issue. 'Ageing is not a disease', 'It is possible to age well'. Seeing ageing as an advantage rather than a burden, as an opportunity rather than a problem needing to be addressed. This is the essential message, which inevitably redefines the way in which recommendations and visions of the future should be read and understood.

Phase III: Analysis and synthesis of visions and recommendations formulated in the Walloon region of Belgium.

Summary of visions

Upon the basis of the discussions which took place during the two preceding phases, each group was asked to suggest two visions/recommendations in the last phase of the Scenario Workshop. The scenarios suggested by the PACITA project could be used as background for the working groups, who nonetheless remained free to express other ideas or invite new considerations. Some groups encountered difficulties in drafting a single shared vision to address the theme of ageing in Wallonia in a forward-looking way. Sometimes, some visions were less articulate, while others largely overlapped. Six visions are included in this report, which are presented in greater detail below. Each of these visions was discussed by the groups. They were then presented to the rest of the participants during the plenary session by the groups' reporters, who used their notes and what had been written on the boards to summarise their work. Finally, it is useful to mention that each of the groups was asked to place their vision on a graph with two axes: on the x-axis, the social framework (between collectivism and individualism) and on the y-axis, the provision of healthcare (between a public monopoly and a free market).

List of visions suggested by participants

1) Title of the vision: Enlightened free choice.
2) Title of the vision: Mutual support between older people and other segments of society.
3) Title of the vision: Free choice of residence.
4) Title of the vision: Innovation and solidarity
5) Title of the vision: Freedom of choice and diversity of provision.
6) Title of the vision: Older people as actors in their life story.

Policy visions

1) Title of the vision: Enlightened free choice.

Description of the vision:

On the basis of an earlier multi-faceted and pluralistic discussion (with older people, experts and workers in the medical sector), it is necessary to create the conditions so that older people can choose, in an enlightened way, their care and life options that correspond to their well-being.

For the time-being, the large proportion of resources is focussed on the medical sector. There are few resources for psychologists or occupational therapists.

It is necessary to change the way of viewing older people. For example, we should not be surprised that it takes an older person 90 minutes to wash themselves, but rather say that it is good that they can wash themselves.

How to address end-of-life issues? Activities may be reduced in order to gain a year or two, but someone may refuse such treatment in order to live life to the full.

Freedom of choice is necessary, but with support: people need to be enlightened about the various stages of life throughout their lives (enlightened decision-making).

The role of the expert is important: they should select what exists in terms of care and technology and present a range of tools for the individual to freely choose from.

Teaching should encourage healthcare professionals to reflect upon the stages of life.

In the medical sector, there is no need to increase the number of actors: consulting several specialists leads to over-intervention because each actor identifies a different problem. They tend to remain within their comfort zones.

What choices and/or political measures are needed to achieve this vision?

Five measures are necessary:

1. Respect for lifelong education.

2. Training professionals.

3. Supporting healthcare workers and ageing.

4. Raising awareness among older people.

5. Promoting the culture of free choice of treatment because often doctors make suggestions which are, in fact, orders.

2) Title of the vision: Mutual support between older people and other segments of society.

Description of the vision:

In the context of this vision, the objective is achieved if:

- Older people can freely make choices about their place of residence.

- A Silver Economy can be constructed which would create jobs for people who are still in good health.

- the voluntary sector creates jobs around older people.

- an intergenerational exchange takes place (expertise, exchange of skills and memory work).

What choices and/or political measures are needed to achieve this vision?

Eight choices or political measures were planned to achieve the set objectives.

1. Ensure the development of professionalism depending on need, training in new technologies.

2. Envisage refunding all care (medication, care and new technology). How? Drawing upon private insurance policies which offer *à la carte* services, depending on various times of life and need. A panel of choices could also be offered which could change depending on age to develop complementary *à la carte* insurance.

3. Working after retirement: leave older people the option of continuing to work if they want to, without losing their pension rights, to enable a transfer of skills and knowledge.

4. Provide financial incentives to develop technology to encourage maintaining independence.

5. Make the caring professions attractive (administrative simplification, increasing salaries, etc.).

6. Widen the range of accommodation and give more freedom in terms of introducing more flexibility, particularly in terms of food hygiene.

7. Funding for these measures would come from several sources: if older people are working, they consume more, which leads to more value-added tax and an increase in taxation on natural persons.

8. Developing a Silver Economy to create wealth.

3) Title of the vision: Free choice of residence.

Description of the vision:

Offer older people the possibility of choosing where they would like to live, regardless of their state of health. And help them stay there.

What choices and/or political measures are needed to achieve this vision?

1. Enable everyone to live where they want and to remain there as long as possible.

2. Encourage them to stay in the same place (human and technical resources: better funding for home helps and new technology).

3. Redirect job-seekers towards these types of jobs by making them more attractive.

4. Develop intergenerational housing.

4) Title of the vision: Innovation and solidarity

Description of the vision:

The main points of this vision are as follows:

- Envisaging changes to the current system rather than a revolution;

- Solidarity;

- Co-ordination between policy makers, service providers and users;

- Innovation, Research & Development.

Care and services should be accessible to all, taking into account the particularities of each individual. In other works, this consists of providing everyone with the possibility of making an enlightened choice. The balance between the public sector and the free market is desirable, because the private sector should not be given too free a rein, and the public sector should be given a regulatory role. In terms of the social dimension, we should go back to basics, even in terms of collective living.

We are fortunate in Belgium to have healthcare system which functions well. The system of social contributions to enable the State to manage healthcare is very important. Healthcare providers should distance themselves from the free market and include in their specifications an obligation of results in terms of social impact. The market should not be able to draw profits from this type of service. The regulator should be able to stipulate in the service providers' specifications, that profits must be reinvested with a social objective.

For example, as some care centres and service centres already offer, a social assistant could conduct and inquiry to identify the needs of older people in their entirety. Based on this, the assistant could help older people to make choices among all the different systems. This would help older people establish the solutions that are best suited to them and which adapt to the changing needs of older people. Connections to external groups should also be considered, particularly with care homes. We tend to think it is a negative thing to go into a care home, while in reality, care homes can provide many positives if they are not left until the last minute. There is a need to change the perception of care homes. They are homes. The same can be said for day centres. Finally, it is desirable to improve volunteering practices. But one person would need to coordinate all this depending on the older person's needs.

The starting point should be the needs of the user, although there is a tendency to start with the solutions that can be imagined. The needs of users are particular and subjective. There is a need to strengthen the coordinating role to better serve patients at home. This means coordinating different sectors (technology, housing, supervision, etc.) as well as individual discussions with a professional. In Flanders, there are people whose role it is to support patients in choosing services and goods which they need to improve their quality of life, in their environment (these people act as healthcare intermediaries, to help the user). There is a need to depart from the usual way of looking at health and to recognise the role of services which support the healthcare sector.

The paradigm which is currently in place in Belgium should be brought back into question:

1) Expenditure on healthcare is significant. Funding for acute care should be reduced to provide more resources for chronic care.

2) Resources could be retrieved from the funding of acute care which could be re-injected into providing chronic care.

Finally, there should be more coherence in terms of public policies, because the current approach is not sufficiently comprehensive, which means spending is not effective (efficiency problem).

In this vision, there is therefore a need to manage a tension between, on the one hand, public authorities as regulatory bodies (standards, regulations, scheduling, equity, maintaining solidarity) and, on the other, the private sector with an innovative role (considering that everyone has an interest in producing things which are good for health). Another tension relates to the issue of solidarity between older people who help and those who need help. Solidarity and volunteering must be maintained at all costs. Despite the fact that we live in an individualistic society, there are strong solidarity mechanisms which should be maintained. It is important to reconcile technological innovation with maintaining solidarity.

What choices and/or political measures are needed to achieve this vision?

1. Training and professionalisation.

2. Creating new jobs.

3. Need for sufficient resources to match the real needs of the population.

4. Transfer of budget from acute to chronic care.

5. Supporting innovation (types of accommodation, alternative funding, technology).

6. Evaluating existing measures, incorporating the collection and promotion of good practice.

7. Creating a body that brings together professionals from all relevant sectors and/or strengthening the Higher Council on Health.

8. Involving consultative councils in decision making bodies.

5) Title of the vision: Freedom of choice and diversity of provision.

Description of the vision:

The aim is that people reaching the end of their lives can really chose where they want to live the rest of their lives (remaining at home, going into a care home, benefiting from day care, etc.). The problem is that the current system is blocked (long waiting lists, lack of places in care homes), and people take the first option open to them even when it is not the best suited to their situation.

There is a need to improve salaries and status of people who work in the healthcare sector. This will increase their motivation to help older people and hence improve their quality of care. Simultaneously, the population needs to be informed of what is available. For example, people are not always aware what a day care centre or service centre is. The same is true of technology.

The public sector can do just as well as the private sector. The CPAS levels of debt are too high. This is also an opportunity to make money in the public sector. There is an issue because, for the same number of beds, the private sector makes profit while the public sector doesn't.

People should be encouraged to stay in their own homes. Structures should be developed to assist with this (e.g. daycare centres) Carers also need help with their tasks and should be recognised for what they do.

Establishing mechanisms whereby unemployed people, while waiting for paid work, could help older people, for example for two hours per week, could also be envisaged.

Finally, social security is an exceptionally motivating tool, which does not fall entirely into public hands. This would no longer be seen if social security is regionalised, which reflects a more politicised vision. Moreover, regionalisation is not consistent (nurses and physical therapists continue to depend upon the Federal government). The problem is that this will soon fall entirely within regional policy, which risks reducing the circulation of information, in contrast to the current situation at the federal level with the system of social consultation.

What choices and/or political measures are needed to achieve this vision?

1. Provide information on and promote what exists. To do so, there is a need for a co-ordination platform between the various stakeholders.

2. Ensure that information circulates in both directions: both towards professionals and towards users. It should be noted that even professionals in the sector can find themselves disoriented and do not recognise all the opportunities that exist for older people.

3. Make it easier to open care facilities for older people. Our current political and bureaucratic structure is one 'that even Moscow would no longer want'. Today, for a care home or daycare centre to open, another home has to close.

6) Title of the vision: Older people as actors in their life story.

Description of the vision:

Taking the older person as an actor in his or her life story as the starting point, means defining that person as an actor from the point of view of their human, social (both urban and rural) and technological (equipment, adapting the environment) environment. This vision starts with the individual and moves towards the community.

The vision is built in a participative manner. Users, policies and experts are involved in constructing a vision to ensure a divers range of points of view. The older person is at the centre and other actors are found in the surrounding areas.

There is a need to break down divisions between the different levels of life (hospital/care home) and to ensure clearer communication of information from one living environment to another, because people can sometimes lose their routine and their bearings.

There is also a need to encourage the creation of other, temporary accommodation, in order to increase the range of choice. 'Kangourou' accommodation, which is accommodation adapted to house different generations, is an example which can be used as inspiration.

It has to be possible to rely upon volunteers who are well trained to deal with the diversity of situations which they may encounter. Ideally, a fair balance between the public and private sector is the best of solutions: if everything falls to the public sector, there would be a tendency to standardise things towards the bottom and if everything falls to the private

sector, part of the population is left by the wayside. The voluntary sector is currently under-represented and should be promoted. This shouldn't only be in times of crisis but also as a means of prevention.

There is a need to limit the number of Ministers/decision makers on the sectoral level because this slows things down. Why not have a Minister responsible for the ageing population?

Professionals who treat older people should be equipped with the technological resources needed, with a view to making technology available to all.

Regional and federal solidarity should be encouraged.

There is a need to redefine older people to create a single, evolving and preventative record of older peoples' needs and desires (placing the older person at the centre of freedom of choice). In this idea, the older person would participate in creating their own record. Development and management of the record could take place through a platform like the CLIC models (Centre Local d'Informations et de Coordination) which operates on geographically structured zones. The CLICs are centres of expertise, care and information on new technology specifically for older people. Adjustable geographic platforms could therefore be envisaged, according to local characteristics in order to avoid uprooting people and keeping them within the area that they live and are used to, as well as maintaining their social networks.

What choices and/or political measures are needed to achieve this vision?

1. Streamline decision makers and reduce their numbers. To do so, power should be devolved to the local level (to a more operational level).

2. Create a regional support unit to coordinate the geographic platforms. Establish a platform which makes all relevant information visible to enable older people to think and plan the stages of the end of their life.

3. Organise preventative health campaigns to educate people to think about their ageing and to engage them. Need to focus on educating the population and policies (regional).

Political visions - summary

These visions focus on individual free choice. This free choice must be the result of full information. This is why a whole series of policy measures are suggested to enable this to take place. They also stress the accessibility of care.

They highlight older people as actors, rather than as people who are not expected to be capable of taking the right decision about themselves, but at least have the means of valuably participating.

Generally speaking and to address the comments of several participants, these visions suggest 'evolution rather than revolution'. The healthcare system in Wallonia and in Belgium operates well. There is therefore no need to overhaul the entire system but to improve what is already there.

Finally, it should be specified that all groups, when it came to positioning their vision on the two-axes graph (social context - provision of healthcare) presented above, invariably positioned their vision in the centre, at the intersection of the two axes.

Feedback and reflections on the method

At the end of the day, the participants were invited, if they so wished, to leave their impressions - good or bad - on the day and the activities. Few comments were made. They are given here to reflect the participants' impressions of the day.

Those of facilitators, the moderator and the reporters have been summarised by the authors of this report.

Preparations

From participants

'Congratulations on organising the day. Good methodology, although it was fast paced. Well done on analysing the content of all the points raised. I hope this day will encourage everyone to think more. '

'Reflections on the position [on the vertical/horizontal axes]: perhaps a bit extreme in their position on the x-axis and y-axis ... how was this relevant to the results of the day? '

'Positive points: (1) variety of participants in the workshops, (2) strict but effective timing.'

From facilitators, the moderator and reporters

The success of this Scenario Workshop in methodological terms was due to two things. First, the organisers were able to rely both on the instructions received during the preparatory sessions on the Scenario Workshop methodology in Bern (January 2014) with feedback from Benedikt Rosskamp following his participation as moderator in a Scenario Workshop which took place earlier in Austria (April 2014). In this way, a whole series of practical problems were easily avoided (timing issues, clarifying instructions received in Bern, specifying certain definitions used, suggestions for facilitators and adapting the organisation of groups which we wanted to be varied and identical throughout the day).

Secondly, the briefing by Pierre Delvenne, coordinator of the Scenario Workshop, for all facilitators and reports also enabled the organisers' objectives to be clarified, as well as the aims of the day and that of each phase of the day. Each facilitator and reporter received clear instructions, leaving little room for doubt during the event; each of the phases were timed (both by the reporter and the coordinator), a document with more specific instructions was provided for each stage of the day and the coordinator ensured all instructions were respected in order to ensure that all the groups were operating under the same conditions.

Group work process

From facilitators, the moderator and reporters

Satisfactory group dynamics

Generally speaking, the exercises worked well: the objectives defined for each part were achieved in a fairly good atmosphere, where everyone was able to express themselves.

The participants showed themselves to be very receptive to the instructions given by the facilitator. Each of the phases of reflection took place under conditions of mutual respect (no raised voices, no participants spoke over anyone else).

Finally, it should be noted that one person preferred not to take part in the day's discussions because she felt she wasn't competent to do so.

Suggestion for improving in future exercises

The participants sometimes found it difficult to position their model on the suggested graph.

On a practical level, the way in which some groups worked was sometimes interrupted by the close proximity of another group.

Nobody criticised the method established, with the exception of the creation of two visions. Despite the instructions that had been given by the coordinator, the participants (often supported by their facilitator) considered that a single vision was sufficient and that they couldn't imagine a second one. They also felt that there was not enough time to come up with a second vision. The coordinator insisted that the instructions were respected and that, as far as possible, two visions be formulated by each group. This partly explains why overall, the authors of this report retained six visions because they were those which the most developed and which most corresponded to a joint, forward-looking vision of concrete policy measures.

The tight timescale could not always be adapted to each of the phases. Sometimes too long, sometimes too short (when formulating visions for example).