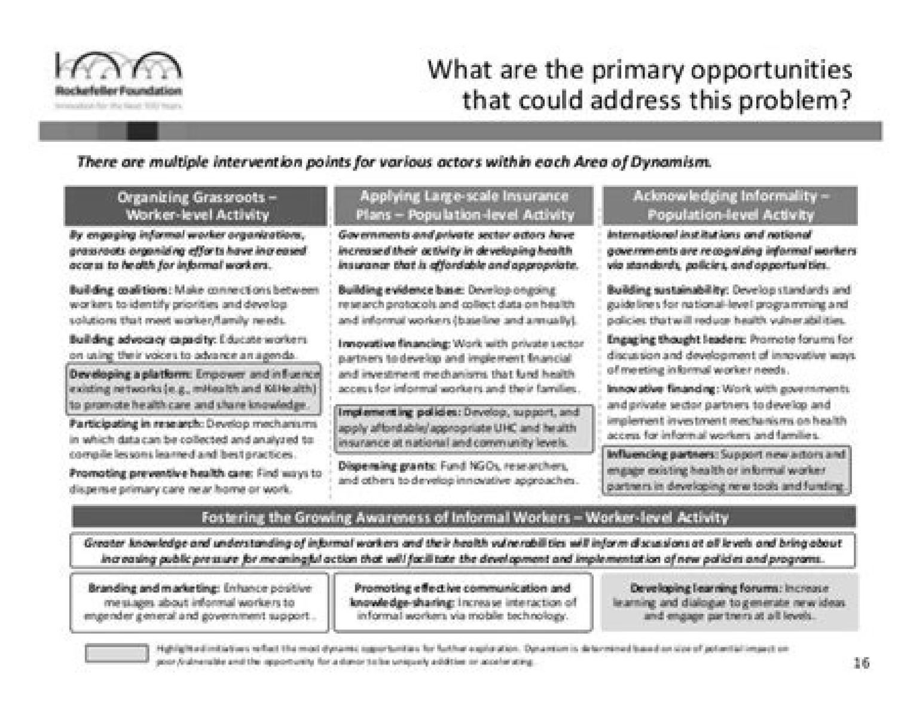
Informal reporting in aged care

I'm not robot!


Rockefeller Foundation
What are the primary opportunities that could address this problem?
There are multiple intervention points for various actors within each Area of Dynamism.
Organizing Grassroots – Worker-level Activity
By engaging informal worker organizations, grassroots organizing efforts have increased access to health for informal workers.
Building coalitions: Make connections between workers to identify priorities and develop solutions that meet worker/family needs.
Building advocacy capacity: Educate workers on using their voices to advance an agenda.
Developing a platform: Empower and influence existing networks (e.g., mHealth and KilHealth) to promote health care and share knowledge.
Participating in research: Develop mechanisms in which data can be collected and analyzed to compile lessons learned and best practices.
Promoting preventive health care: Find ways to dispense primary care near home or work.
Applying Large-scale Insurance Plans – Population-level Activity
Governments and private sector actors have increased their activity in developing health insurance that is affordable and appropriate.
Building evidence base: Develop ongoing research protocols and collect data on health and informal workers (baseline and annually).
Innovative financing: Work with private sector partners to develop and implement financial and investment mechanisms that fund health access for informal workers and their families.
Implementing policies: Develop, support, and apply affordable/appropriate UHC and health insurance at national and community levels.
Dispersing grants: Fund NGOs, researchers, and others to develop innovative approaches.
Acknowledging Informality – Population-level Activity
International institutions and national governments are recognizing informal workers via standards, policies, and opportunities.
Building sustainability: Develop standards and guidelines for national-level programming and policies that will reduce health vulnerabilities.
Engaging thought leaders: Promote forums for discussion and development of innovative ways of meeting informal worker needs.
Innovative financing: Work with governments and private sector partners to develop and implement investment mechanisms on health access for informal workers and families.
Influencing partners: Support new actors and engage existing health or informal worker partners in developing new tools and funding.
Fostering the Growing Awareness of Informal Workers – Worker-level Activity
Greater knowledge and understanding of informal workers and their health vulnerabilities will inform discussions at all levels and bring about increasing public pressure for meaningful action that will facilitate the development and implementation of new policies and programs.
Branding and marketing: Enhance positive messages about informal workers to engender general and government support.
Promoting effective communication and knowledge-sharing: Increase interaction of informal workers via mobile technology.
Developing learning forums: Increase learning and dialogue to generate new ideas and engage partners at all levels.
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The dynamics of informal care provision in an Australian household panel survey:
Previous work characteristics and future care provision

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Abstract: This study contributes to a small literature on the dynamics of informal care by examining the informal care provision choices of working age Australians. We focus on the impact of previous work characteristics (including work security and flexibility) on subsequent care provision decisions and distinguish between care that is provided to people who cohabit and people who reside elsewhere, as well as between the provision of care as the primary caregiver, or in a secondary caring role. Our dynamic framework of informal care provision accounts for state-dependence, unobserved heterogeneity and initial conditions. For both males and females, we find the existence of positive state-dependence in all care states in both the short- and medium-term. Furthermore, the inertia in care provision appears to be stronger for more intensive care. We also find previous employment status has a significant deterrent effect on current care provision decisions. The effects on employment, however, differ according to the type of previous work, the type of care currently provided, and the gender of the caregiver. We also find that workers with perceptions of greater job security are nevertheless less likely to provide subsequent care. Our results also suggest that workers' perceptions about work flexibility and their stated overall satisfaction with work actually have no impact on their subsequent decisions to provide care in any capacity.

Keywords: informal care, labour supply, dynamic multinomial choice models, panel data.

JEL classification: C23, J14.

Taiwan Outstanding Photonics Product Award 2013

Chunghwa Picture Tubes, LTD. — Touch Embedded Portrait / Landscape 3D Display

Product Introduction

This product, CPT Touch Embedded Portrait/Landscape 3D Display, can support not only display 3D content in portrait and landscape but also provides suitable multi-touch gestures for 2D and 3D mode separately. And the 3D module of the product already included a capacitive multi-touch sensor for multi-touch gesture, so it doesn't need an additional touch module. For this reason, the display module can be made thinner. Besides, 3D format data can be converted to 3D contents automatically and displaying contents can be recognized to switch 2D or 3D display mode automatically. There is no doubt that it will bring the users an amazing user experience in operation and vision respect.

Product Features

Technology: The 3D module with 3D Portrait/Landscape LC-Barrier technology included a capacitive multi-touch sensor so it doesn't need an additional touch module and the display module of the product can be made thinner, easier and low cost.

Innovation: CPT Touch Embedded Portrait/Landscape 3D Display can display 3D content in portrait and landscape.

Market: At present more and more smartphone products with 3D module are presented, and the operating systems of smartphone are getting more and more perfect. For these reasons, CPT will go with this stream to extend 3D portable device market demand and enlarge 3D portable device market share.

Design: The main design for this product is to bring the users friendly and intuitive interface. For this reason, the portrait/landscape switch is controlled by G-sensor, and the product can switch 2D/3D automatically and executes suitable gesture, such as pinch gesture, etc., in 2D and 3D mode according to the content is displayed.

Other advantages: It can recognize file format and then execute 2D to 3D conversion automatically. All switches, such as 2D/3D switch, portrait/landscape switch, etc., are automatic. These designs and features make the users feel easy to use and more comfortable after they have watched display for a long time.

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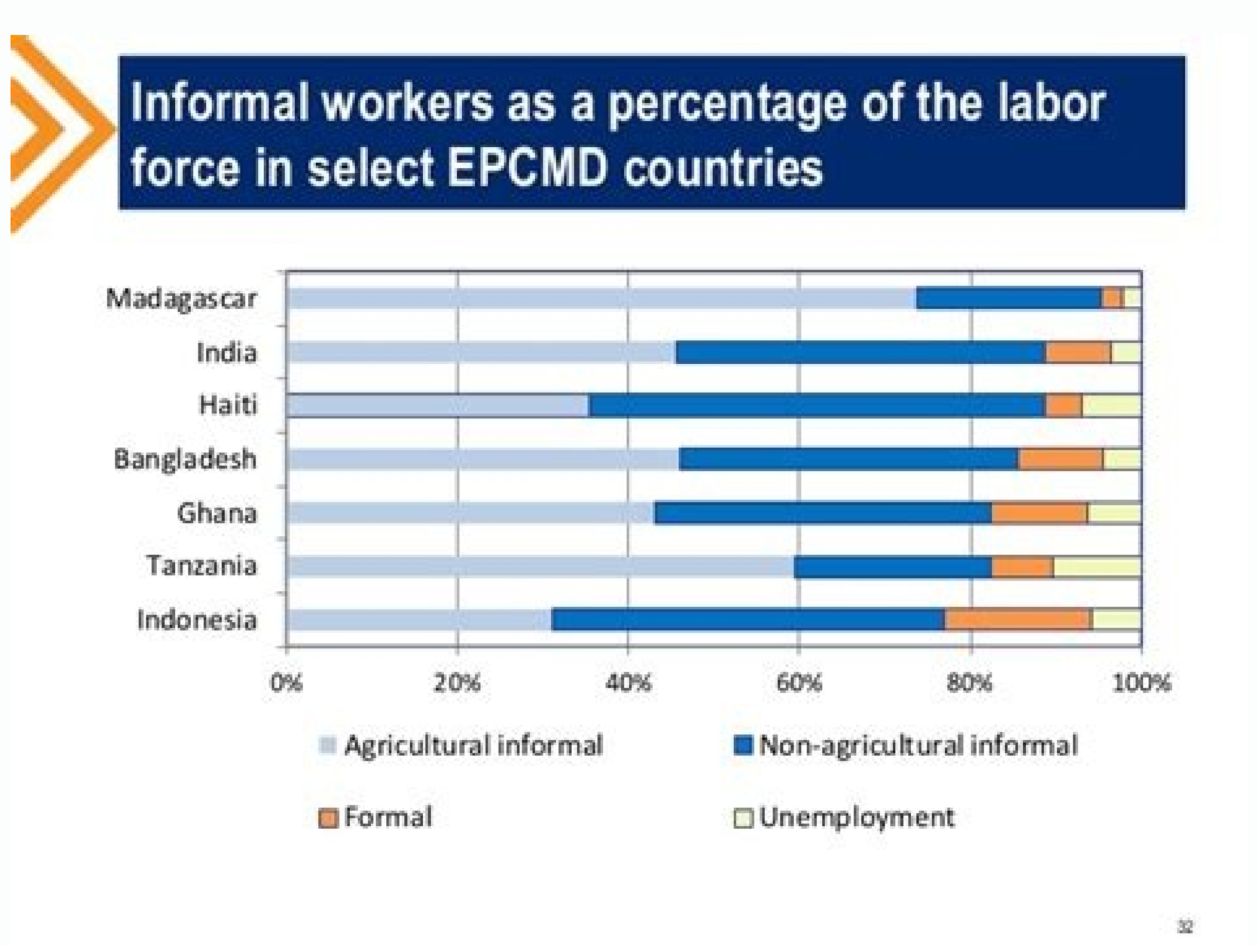

Formal and informal reporting in aged care. Informal written reporting requirements in aged care. Informal and formal reporting requirements of an organisation in aged care. Example of informal reporting in aged care. What is formal reporting in aged care. Formal and informal reporting requirements in aged care. What are some informal and formal reporting requirements in aged care. Informal reporting requirements in aged care.

Your download will start in a few seconds. If it does not start automatically please click here. Carers Australia and the National Carer Network are calling on the Government to address the systemic issues with home care and supports for informal carers following the findings of the Royal Commission into Aged Care Quality and Safety (the Commission). Carers Australia is encouraged that the Commission has embraced many of the recommendations that were highlighted in our three submissions, two appearances before the Commission, and submissions from the National Carer Network members. Carers Australia CEO Liz Callaghan said, “We welcome the recognition by the Commission that informal carers are a critical element of the care system for older Australians and stronger supports for them are long overdue.” In particular, we are heartened to see the Commission has considered informal carers within the proposed establishment of a new Act supporting older Australians receiving care, and includes the right of informal carers to reasonable access to supports in accordance with needs and to enable reasonable enjoyment of the right to social participation. “The Commission has highlighted a clear common theme in what the community expects from the aged care system which includes the desire for a good quality of life and ageing at home. This can only be achieved if informal carers are supported in their role with readily available respite, training, and support services,” said Ms Callaghan. “What we are hearing from informal carers and their loved ones is that they are not able to receive quality respite care when needed and the extended wait times to access these services are leading to carer burnout. This is unacceptable, and something we have repeatedly called on the Government to address,” said Ms Callaghan. Carers Australia is therefore asking the Government to fund all outstanding home care packages for older Australians as a matter of urgency, as this will support informal carers and improve their own health and wellbeing. “Many older Australians would prefer to remain at home for as long as possible and this is usually facilitated by informal carers. By funding home care packages, informal carers will know their loved one is being looked after and this will lessen the stress and anxiety they often experience.” Another key recommendation from the Commission was establishing and funding a community-based Carers Hub network which will enable direct referral and information sharing for informal carers. “We have long recognised the importance of informal carers accessing information and support from peers as part of a seamless service system where informal carers can access what they need from other informal carers and providers at the same time,” said Ms Callaghan. “But without clarification from the Government regarding how this Carers Hub will function, we caution that any implementation of a new network must involve integration with Carer Gateway as those providers, which include much of the National Carer Network, have already undertaken important work in building relationships and trust with local informal carers.” Carers Australia will monitor the implementation of these recommendations from the Commission in the coming months and stands ready to work alongside the Government and other stakeholders to implement the recommendations. “We thank the Commissioners and all the informal carers who have played a crucial role in informing the recommendations of the Commission,” said Ms Callaghan. “We will continue to support informal carers to have their voices heard and advocate for their needs and supports at a national level.” The EU is currently experiencing unprecedented demographic changes. The share of population above 65 years old in the EU is expected to increase from 19 % in 2016 to 29 % by 2080, and the percentage of people above 80 years old will more than double to 13 %[1] in that time. A rapidly ageing population leads to an ever-growing need for long-term formal and informal care. In 2017, one in four people in the EU had a long-term disability, women (27 %) more than men (22 %)[2]. Given this context, the EU will face a major challenge in meeting LTC needs in a financially sustainable way, ensuring care is affordable without endangering the quality of services or the lives of care providers and the cared-for (European Commission, 2017a). LTC is ‘a range of services and assistance for people who, as a result of mental and/or physical frailty and/or disability over an extended period of time, depend on help with daily living activities and/or [are] in need of some permanent care’ (European Union, 2014). LTC can be performed either formally by paid professionals or informally by family members, relatives, friends or others. LTC systems vary significantly across EU Member States, with differences in the extent of provision, benefits and services provided and institutional settings (Spasova et al., 2018). In the EU-28, LTC relies heavily on informal care, with evidence indicating that the number of informal carers is twice that of formal caregivers (European Union, 2014). The prevalence of informal care might be associated with the lack of accessible, affordable and good-quality formal LTC facilities and services (Spasova et al., 2018). In many Member States, formal home-care services remain underdeveloped and difficult to access. As such, research highlights the increasing role of domestic workers, often migrant women, in the provision of LTC at home in several EU Member States (Spasova et al., 2018). Due to a higher life expectancy, more women than men are in need of LTC. In addition, the vast majority of formal and informal carers are women. Women’s greater involvement in informal care, which negatively impacts their participation in the labour market, also increases their risk of economic dependency, poverty and social exclusion. In the EU, almost one in every three inactive women (32 %) aged 20-64, compared to just 5 % of inactive men in the same age group, is not in paid work due to family and/or care responsibilities[3]. Evidence of greater degrees of chronic stress and depression among female caregivers has also been found as women often have to combine care responsibilities with household chores and work (Schultz, 2008). The availability, accessibility and affordability of care facilities are, therefore, crucial elements allowing carers, especially women, to stay in or enter the labour market and to reconcile work and life duties and needs. The European Pillar of Social Rights endorses everyone’s right to accessible, good-quality and affordable LTC services, and in particular home care and community-based services. The 2019 directive on work—life balance for parents and carers also introduced a new right for workers to take at least 5 working days per year of carers’ leave where a relative has a serious illness or dependency. These provisions aim to remove some of the barriers faced by informal carers, especially women, to both entering and staying in employment. The development of sustainable models of care delivery is of high political importance in the EU. For instance, the Social Protection Committee and the European Commission are promoting new ways to provide adequate and sustainable LTC services in ageing societies through investment in preventive care, rehabilitation and age-friendly environments. As part of this process, the European Commission launched the blueprint on digital transformation of health and care in 2016. This initiative highlighted the potential of digitalisation in helping informal carers to maintain an active and productive life while providing care for their dependents (European Commission, 2016a). Women bear the brunt of long-term informal care duties More women than men assume long-term informal responsibilities at least several days a week or every day. Overall, women represent 62 % of all people providing LTC in the EU[4]. At EU level, the informal LTC rate for older people and/or people with disabilities was 15 % for women and 10 % for men in 2016. Significant variations exist between and within Member States in the number of informal carers (Figure 39). The share of people who report that they are providing informal LTC reaches 32 % for women and 20 % for men in France, whereas in Germany it is as low as 5 % for women and 7 % for men. There is nearly equal distribution of care duties in Sweden, Romania, Croatia and Estonia (0.8 p.p.), and gaps as high as 13 p.p. in Belgium, 11 p.p. in France and 10 p.p. in Malta. Despite a large variety of formal LTC systems, the disproportionate distribution of informal care duties to women’s disadvantage is a persistent pattern across the EU-28. Figure 39: Percentage of women and men caring for older people and/or people with disabilities at least several times a week (18+), 2016 (Indicator 3) Note: * Germany is noted to be the only Member State where slightly more men than women care. The question asked: In general, how often are you involved in any of the following activities outside of paid work? (D) Caring for disabled or infirm family members, neighbours or friends under 75 years old; (E) Caring for disabled or infirm family members, neighbours or friends aged 75 or over. Answers ‘every day’ and ‘several days a week’ were used. Member States are grouped on size of the gender gap. ‘Considerably more’ — gender gap is higher than 5 p.p.; ‘somewhat more’ — gender gap varies from 1 to 5 p.p.; ‘no gap’ refers to a gender gap from – 1 to 1 p.p.; within the group, Member States are sorted in descending order. When interpreting the differences among Member States, it is important to take into account the subjectivity in assessing involvement in LTC. The EQLS did not provide a definition of ‘care’. As a result, ‘providing care’ can be understood as encompassing a vast range of actions of varying intensity, from the maintenance of social links to support for daily activities or even near-medical care. Older women most likely to be long-term informal carers Women of pre-retirement age (50-64 years) are most likely to take care of older people and/or people with disabilities. In the EU, 21 % of women and 11 % of men of this age provided LTC every day or several days a week in 2016, compared to 13 % of women and 9 % of men aged 25-49 years. About a third of women aged 50-64 years in Belgium (37 %), France (33 %) and Latvia (33 %) provide care at least several days a week (Figure 40). The difference in informal LTC rates between women aged 20-49 years and women aged 50-64 years is particularly striking in Poland (– 17 p.p.), Spain (– 17 p.p.), Greece (– 16 p.p.) and Belgium (– 16 p.p.). Similarly, in 22 EU Member States, men of pre-retirement age (50-64 years) are more likely to provide LTC than younger men (20-49 years). The highest percentage of men of pre-retirement age involved in informal care are found in Latvia (28 %), France (21 %) and Estonia (17 %). Figure 40: Percentage of women and men caring for older persons and/or persons with disabilities at least several times a week (50-64 years), 2016 Note: Member States are grouped on size of the gender gap. `Considerably more’: gender gap > 5 p.p. `Somewhat more’: gender gap 1-5 p.p. `No gap’: gender gap from - 1 to 1 p.p. Within the group, Member States are sorted in descending order. As well as differences between age groups, there also are gender gaps within different age groups. Overall for the EU there is a 10-p.p. difference among women and men of pre-retirement age and a 4-p.p. gap among those aged 20-49 years. In 21 EU Member States, gender gaps among the 50-64 age group follow a similar pattern, reaching 22 p.p. in Belgium, 19 p.p. in Greece and 19 p.p. in Spain (Figure 40). There are only two Member States (HU, HR) where the share of women and men informal carers aged 50-64 is about equal, and three Member States (CZ, PT, EE) where older men are slightly more likely than older women to provide LTC. The intersection of gender and age underscores the particularly disadvantaged position of older women in the gender division of informal care responsibilities and the challenge that intensive care poses on their work—life balance. Although people aged 50-64 years are still economically active in a large number of Member States, their employment rates are much lower, especially for women involved in informal care. Long-term care duties intensify gender inequalities in employment, particularly for women A closer look at people who are in paid work and who are also providing LTC on a regular basis gives an insight into how many employed people have added pressure on their work—life balance. A large share of employed people, particularly women, combine work with care responsibilities. In the EU, 13 % of all working women and 9 % of working men were providing care to older people and/or people with disabilities at least several times a week in 2016 (Figure 41). In 21 EU Member States, a larger proportion of working women provide informal LTC. On the other hand, in four EU Member States (RO, SE, IE, PT), working men account for a bigger share of carers. In Austria, Germany and Czechia, the gender division is almost the same. Figure 41: Percentage of employed women and men caring for older people and/or people with disabilities at least several times a week (18+), 2016 (Indicator 4) Note: Member States are grouped on size of the gender gap. ‘Considerably more’: gender gap > 5 p.p. ‘Somewhat more’: gender gap 1-5 p.p. ‘No gap’: gender gap from – 1 to 1 p.p. Within the group, Member States are sorted in descending order. In general, women and men providing LTC are less likely to participate in the labour

market. In the EU, 42 % of women and 56 % of men taking care of older people and/or people with disabilities every day or several days a week in 2016 also had paid jobs, compared to 47 % of women and 58 % of men without care responsibilities (Figure 42). Figure 42: Percentage of women and men caring for older people and/or people with disabilities at least several times a week who have a paid job (18+), 2016 In all but four EU Member States (DK, DE, EE, ES), men carers are more likely than their women counterparts to be in paid work. The largest gender gap is observed in Romania (– 42 p.p.), where only 36 % of women providing LTC are engaged in paid work. Gender differences are also significant in Italy (– 35 p.p.), Austria (– 33 p.p.) and Portugal (– 28 p.p.), where one in five women involved in informal care have a paid job. In contrast, the smallest gender gaps are found in Spain (0.2 p.p.), Poland (– 4 p.p.) and Croatia (– 5 p.p.). The gendered nature of care responsibilities is evident across all age groups. Among those aged 20-49 years, women caring for older people and/or people with disabilities participate in the labour market by 8 p.p. less than women without such responsibilities and by 19 p.p. less than men carers. Men's employment rate in this age group is high, regardless of their involvement in informal care (Figure 42). Women of pre-retirement age (50-64 years) are even more negatively impacted. Fewer than one in two women (48 %) providing LTC is employed, in comparison with 66 % of men. Among those who are inactive, every tenth woman aged 50 years or more reports that family or care responsibilities are the main reasons for taking a career break and/or not seeking a job (EIGE, 2016b). Informal caring duties can also lead to early retirement for older carers, particularly women (European Commission, 2013). Research suggests that the impact of informal care provision on work might vary due to different factors, including the number of hours of care provided, whether care is provided to a co-resident or someone living outside the household and the availability of formal care services (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011). The intensity of care is another important variable in assessing the impact of care work on the mental health of carers. In fact, caring for more than 20 hours a week is linked to a 20 % higher prevalence of mental health problems among carers than for non-carers (Colombo et al., 2011). Overall, in Member States where women disproportionately bear the burden of LTC, gender inequalities in labour participation are higher. In fact, EU Member States with larger gender gaps in the provision of care for older people and/or people with disabilities have lower scores in the sub-domain of participation in the labour market (r = 0.3338 *) (Panel A in Figure 43). For instance, Belgium has the highest gender gap in care, with 26 % of women and 12 % of men providing care (gender gap – 13 p.p.), as well as one of the lowest scores in the sub-domain of participation (78.2 points). Furthermore, scores for this sub-domain are lower in Member States where the gender division of care duties among those of pre-retirement age (50-64 years) is particularly unequal (Panel B in Figure 43). Figure 43: Score of the Gender Equality Index work sub-domain of participation, and (A) the gender gap informal LTC rate (Indicator 3, 18+) and (B) the gender gap in the informal LTC rate (age group 50-64). Note: EIGE's calculations, EQLS, Gender Equality Index, (*) refers to significance at 10 %. One in three households live without adequate care In the EU, 29 % of households reported unmet needs for professional home-care services in 2016[5] (Figure 44). Among Member States, this figure ranges from 12 % in Sweden to 86 % in Portugal. Some of the most common reasons reported by households are affordability (49 %) and lack of available care services (15 %)[6]. For instance, in Cyprus, Romania and Poland, the cost of professional home-care services is an obstacle for up to 85 %, 80 % and 71 % of households respectively. Figure 44: Percentage of women and men reporting unmet household need for professional home-care services (16+), 2016 (Indicator 5) Note: Data on Denmark is not available. Certain groups of the population may have more difficulty in accessing formal LTC services, including people with low income, poorly educated people, migrants and ethnic minority women (European Commission, 2009). As a result, households are forced to provide care themselves or, in some Member States, to outsource care to domestic workers, who are very often migrant women. In Italy, for example, three in four home carers are migrants (European Commission, 2013). The situation of migrant domestic workers engaged in informal care is of major concern. Most care migrants have irregular contracts which generally implies precarious working conditions and limited access to social-protection rights (Spasova et al., 2018). 'Unmet need' is a subjective measure which does not provide an insight into the type of needs that are not met in different Member States as people's living conditions and available services vary across Member States. The reporting of unmet needs was slightly higher in the households where a woman responded to the survey (30 %) than where a man responded (28 %). Women are more likely than men to report an unmet need for professional home-care services in all but six Member States (LU, NL, AT, PT, SE, UK). This may be due to their greater involvement in informal care. Moreover, older women tend to live alone more often than men, and therefore may be in need of care to a greater extent. Inability to access professional care services when needed not only impacts upon the quality of life of the person in need of care, but may also force others to allocate more time to caring. This can have far-reaching effects on their ability to combine paid work with care duties. In addition, it can prevent their access to better-quality jobs and negatively affect their employment status and the number of hours they can engage in paid work (ILO, 2018a). Considerable differences exist across Member States as regards unmet needs for professional home-care services and the levels of gender equality achieved. Among other things, this shows that different ways of organising professional home care could contribute to gender equality, and that there is still huge room for improvement in many Member States where gender equality could be further boosted across different areas of life. As demonstrated by Figure 45 (Panel A), the highest levels of gender inequalities in the use of time, as measured in the Gender Equality Index's domain of time (particularly in the sub-domain of social activities), are noted in Member States (e.g. EL, PT) with very large shares of households with unmet needs for professional home-care services (r = – 0.4646 *). In contrast, Member States with the best gender-equality achievements in the use of time (e.g. SE) are noted to have very few households with unmet needs for professional home care. Furthermore, care infrastructure is noted as being particularly linked to women's career prospects. In Member States where households reveal high levels of unmet needs for care services, women are noted to have lower scores in career prospects[7] (r = – 0.5863 *) (Panel B, Figure 45). The same connection, although to a marginally lesser extent, exists for men — the higher the level of unmet needs in the household, the poorer the career prospects of men on average. Figure 45: Unmet care needs for older people and/or people with disabilities, and (A) Gender Equality Index score of time domain and (B) career prospects index scores for women (16+) Note: EIGE's calculations, EU-SILC, Gender Equality Index, * refers to significance at 10 %. Data on Denmark is not available. Footnotes [1] Eurostat, Population projections, 2015 (proj_15ndbims). [2] Eurostat, Health variables of EU-SILC, 2017 (hlth_silc_06). [3] Eurostat, EU LFS, 2018 (lfsa_igar). [4] EIGE calculation, Eurofound, EQLS. [5] 27 EU MS, data for Denmark is not available. [6] EIGE's calculations, EU-SILC, 2016. [7] Prospects Index is a composite indicator used in the domain of work of the Gender Equality Index. It was developed by Eurofound and vcombines indicators on employment status, type of contract, prospects for career advancement as perceived by the worker, perceived likelihood of losing one's job and experience of downsizing in the organisation. Parental-leave policies Informal care of children and childcare services