

Vision statement



New professionalism
in care and support
as a task for the
future

An exploratory framework

Brussels, 17 December 2015

Request for advice: /
Person requesting advice: /
Receipt of request for advice: [Click here to enter a date.](#)
Advice period: Advice at own initiative

Approval/confirmation by Board: 17 December 2015 unanimous

Contents

Introduction.....	4
New professionalism in care and support as task for the future - exploratory framework	6
1. Quality of life in postmodern society	6
1.1. A changing society.....	6
1.2. Quality of life.....	9
1.3. Seeking answers	11
1.3.1. A more generalist approach needed.....	11
1.3.2. Connectedness as a precondition for autonomy.....	13
1.4. The person with care needs and the citizen	14
2. What do we expect of the professional?.....	16
2.1. The care and support professional.....	16
2.2. Generalist competencies	17
2.3. The essence of professional activity in care and support	19
2.3.1. Quality of life as the aim of the care and support relationship.....	19
2.3.2. Supporting self-care	25
2.3.3. Sharing care and support with family caregivers	27
2.3.4. Strengthening social cohesion.....	28
2.3.5. Being sensitive to diversity	30
2.3.6. Use of Technology and ICT.....	32
2.4. It takes two to tango or the perspective of the professional.....	33
2.5. The super professional? Or does the future lie in working together?.....	34
Bibliography.....	35

Introduction

In the recent years the concepts of comprehensive care and support, and (properly understood) socialisation have found their way into many studies, conferences and policy documents. The time is ripe. Initiatives are being taken towards greater comprehensive care and support (CCS) both in the field and policy. Yet comprehensive care and support isn't gaining a sufficient foothold. People with care needs are not yet experiencing comprehensive care and support in the way we truly intend. The question we now must ask ourselves is **how** we can **bring comprehensive care and support up to speed**. Which actions are needed for this?

The dominant (acutely biomedical) care model that we know today stands in the way of the full roll-out of comprehensive care and support. The Strategic Advisory Board Well-being Health Family (hereinafter SAR WGG) described this in its Comprehensive Care and Support Vision Statement (7 December 2012, p.14). It's **time for a fundamentally different comprehensive care and support model** that makes the paradigm shift from problem-oriented **to goal-oriented care and support** and thus also from a supply-driven to **a person and needs-driven model**.

This paradigm shift - which goes together with a trend towards greater socialisation - can only take place if it's at the same time able to penetrate to various social systems. These interlinking systems - the political system, education, housing, employment, the labour market, healthcare, social security including social services - can provide comprehensive care and support only if they could work together.

In the present advisory document, SAR WGG is focusing first of all on the professional. The Board indeed considers that **professionals themselves have an important role to play in making the paradigm shift**. We expect professionals to provide care and support which are focused on the quality of life, for supporting people with care needs (and their immediate environment) in their functioning and living as well as in their participation in society. Professionals will need new, more generalist competencies to achieve this.

For professionals to optimally make use of these newly acquired competencies, the context in which they will work must create the necessary space and opportunities. Hence, we will also investigate **how the educational and labour market systems can best adapt** to form these new professionals, give them space, support them, motivate them and keep them involved. The educational system after all will train the professionals who will contribute to realising the paradigm shift in a care and support sector that is receptive to such a shift.

At the same time, the question arises on **how policy can facilitate and drive comprehensive care and support**. The fact that a new perspective on care and support is needed has been demonstrated by many in recent years. It is up to the political system (government and parliament) to define the societal objectives related to the care and support. In this, policy - through regulations and financial incentives - is able to stimulate social systems to contribute to the realisation of this new perspective, and paradigm shift.

The present document contains **PART 1** of the exercise: the exploratory framework. How do professionals work best in realising comprehensive care and support? This section should be read together with the vision on comprehensive care and support outlined by the Board in late 2012. It will further clarify what comprehensive care and support could mean for the professionals. We will quote as necessary from the CCS Vision Statement in the red text in the sidebars.

Part 1 is being distributed as a SAR WGG vision statement. The document will be used by the Board as a framework for developing Part 2, but also to engage in debate with other players. The document can be further adapted in the future based on the insights gained.

PART 2 will be developed in a subsequent phase (January to May 2016) and will focus on how to realise the proposed vision. It after all isn't the intention to simply place all the responsibility on the professional for realising comprehensive care and support. Care and support professionals do not operate in a vacuum. The labour market, education as well as government policy are faced with an enormous task in making the conditions in which professionals will be trained and work receptive for providing comprehensive care and support. We will therefore address three areas in PART 2: alternative forms of working, educating and guidance. Per area, we will examine how to promote (and not hinder) comprehensive care and support. We will see where things (sometimes) go wrong. We will sketch a number of obstacles along the way and make recommendations to address them.

The Board is aware that some facts are intractable. They are rooted in traditions and often have been translated into binding agreement frameworks and regulations. SAR WGG does not intend to create a tabula rasa, but above all wishes to orient thinking in the direction of a common perspective for the future. This means that some of the proposed projects are achievable in the short term, while others will require much more time, consultation and effort.

SAR WGG aims to sketch a **framework** that indicates **what we expect in the future of professionals in the context of the vision on comprehensive care and support**. How do professionals work best in providing comprehensive care and support, and in contributing to the socialisation of care?

Indicating what we expect of care and support professionals requires also indicating **how we expect the education, the labour market and the policy to support professionals and create the space for providing comprehensive care and support**.

The Strategic Advisory Council Welfare, Health and Family advises the Flemish government strategically in order to contribute to the development of policy on health, wellbeing and family care and to formulate policy perspectives for the long-term.

The Council advises both on demand (e.g. by the Flemish government), or on the Council's own initiative.

The Council is composed of 28 stakeholders, designated by the Minister for Welfare, Health and Family, representing the large civil society: supply, service-users, personnel working in the field of well-being, health and family, representatives of socio-economic organizations (e.g. Trade unions, employers, ...). Moreover, there are a limited number of "independent experts" in the Council. The Council largely represent the most important stakeholders in the field of Welfare, Health and Family".

New professionalism in care and support as task for the future - exploratory framework

1. Quality of life in postmodern society

This chapter will introduce the theme. In our complex society, the expectations of citizens and people with care needs as well as their surroundings have changed dramatically. The 'old' answers sometimes don't work any longer. We need to find a new approach to care and support. We will also focus on the concepts used in this text of 'the person with care needs' and 'the citizen'.

1.1. A changing society

In its Comprehensive Care and Support Vision Statement (7 December 2012, p.7-12), SAR WGG described the changes in our society that requires a new perspective on care and support, and a reorientation of the care system.

The atomisation of society due to a change in family structures and less stable family relationships, changes in the labour market with a decline in demand for unskilled labour, an ageing society and a recent greening with specific socio-demographic characteristics, the increase in chronic diseases and multimorbidity, increasing ethnic and cultural diversity, increasing prosperity and the associated growing social inequality and poverty, scientific and technological developments, economic trends towards greater competition, globalisation and localisation individualisation.

Individualisation: The life of each individual is becoming disconnected from predefined rules and instead is being placed in the hands of that individual. This results in greater self-determination, but also in the 'requirement' to live an independent life, outside the traditional life connections, but within the standards of the market, country and peer group. This is not self-evident, especially for the more vulnerable. On the one hand this translates into empowerment, but on the other hand into great uncertainty. A new social divide is created: between those who succeed in using their freedom of choice and those who lack the human capital needed to do so.

- Citizens have become more empowered and assertive, and have high expectations regarding the care and support provided. Along the way, those with chronic conditions and complex life problems have developed their own story and their own expertise. They also wish to use this expertise to organise their own (self) care and, as much as possible, retain control over their lives.
- In addition, our society has become very complex and demanding with regard to the individual. Good social functioning and the ability to constantly reposition and connect in different groups and environments is the key task of our time. Social functioning requires a high degree of sensitivity and makes adaptation an important skill. At the same time, an individual must also develop a stable identity (social, psychological, cultural) on which he or she can rely. (CCS Vision Statement, p. 9)

Sources:

- van Ewijk H. (2010). *Maatschappelijk werk in een sociaal gevoelige tijd* [Social work in a socially sensitive time], Universiteit voor Humanistiek, Utrecht.
- Hermans K. & Desair K. (mei 2009) *Sociaal werk de toekomst in!* [The future of social work] Centrum voor sociologisch onderzoek, K.U.Leuven.

These are developments that have made society as a whole much more complex.

Thus people today who wish to and must thrive in this complexity, are obliged to look elsewhere. Far-reaching **individualisation** (see sidebar) and an **emphasis on autonomy and self-determination** are eye-catching **characteristics of these times**. People with care needs wish to retain control over their lives. A paternalistic approach to care and support will no longer be accepted by many. The 'autonomous' citizen wishes to participate in the decisions that are important to his or her quality of life.

At the same time, our complex and rapidly changing society offers little in the form of guidance. **Individualisation has a downside**. Uncertainty raises many concerns. Many **people become lost**, do not know how to live with uncertainty and thus sometimes need support. Hans van Ewijk (2010, p.10) writes that *the long-standing quest to eliminate poverty, illiteracy and barbarity that led to a cultural offensive changes into the postmodern social issue of the (dys) functioning of humans in an increasingly complex context*. Individualisation and the related idea of own merit and own responsibility also minimise the fact that people remain strongly influenced by their environment, by the opportunities they receive, by their own health ...

Psychiatrist and psychotherapist Dirk De Wachter also describes the issue in 'Borderline Times' (2012, p. 80).

It is likely that we can't integrate everyone in society, but we need to aim for as many people as possible. Not by severely penalising all that goes wrong, but by reflecting on what it is that we are trying to realise together, by thinking about the functioning of society, by dwelling on why lately more and more people no longer seem to be able to keep up, on the fact that people increasingly are becoming derailed or voluntarily dropping out. Thus, the task of the psychiatrist is to fetch people from behind the closed walls and give them a place in society. In severe cases with an ankle monitor if necessary. But this is only possible if society is open to this, if it recognises that some people are more vulnerable. This is contradictory: efficiency thinking and performance pressures are causing more and more collateral damage. People think: 'let the people in white coats solve the problem.' And so psychiatrists and their entourage must help the laggards so that they are again able to participate. Meanwhile, the world continues to eject all who are unable to keep up.

While our support networks are less stable than before, the changes in our society of course have also created new opportunities. We are seeing a transformation to new forms of networks of which we are a part: online, remote contacts, diverse sub-communities These new networks should also give vulnerable groups more opportunities to counter isolation, if we also succeed in better taking advantage of these opportunities.

Recently the United Nations General Assembly formulated 17 Sustainable Development Goals: Transforming our world: the 2030 Agenda for Sustainable Development. Ensuring healthy lives and promoting well-being for all at all ages, quality education, gender equality, and productive employment and decent work are a few of these objectives. The General Assembly considers that these objectives powerfully summarise the challenges faced by our rapidly changing society¹.

Care and support systems and education have also not stood still. They are actively responding to the changes in society. In response to the increasing complexity, **professionals have increasingly begun to specialise**. Each specific part or problem receives its own specialist.

Education trains healthcare specialists to provide answers to technologically complex questions. But specialisation has also gained currency in the well-being sectors. By dividing up the questions and problems and standardising possible answers or solutions, an attempt is made to reduce and get a grip on the complexity. Which also results in an extreme form of *instrumentalisation of professional work* in which professionals are engaged in a *rational system of goals, resources, execution and billing. Products, prices and evidence of effectiveness have become dominant* (van Ewijk & Kunneman (ed.) 2015, pp. 53-54).

¹ UN General Assembly. A/69/L.85

We also note that the tendency of care and support services to **approach** and solve many - societal - **problems individually** is resulting in increasing **medicalisation and therapeutisation** (see sidebar). This *distracts attention from underlying patterns that* cause a lack of well-being and ill health (Visser W., 2013 p.89).

Medicalisation and therapeutisation means that more and more areas are subjected to medical and psychological definitions and standards, and the emergence of new diseases, often driven by media and industry. Because the right to care and support is often linked to a diagnosis rather than a need for care, on the one hand a compulsion arises to diagnose the person with care needs (and/or his or her immediate environment) and on the other hand an increasing “inequity by disease” emerges (SAR WGG, CCS Vision Statement, p.9).

1.2. Quality of life

It's in this complex society that people live. Citizens who sooner or later will need care and support, for themselves or for someone from their immediate environment. These citizens expect a comprehensive response to their demand for support. Comprehensive care and support must contribute to the quality of life of people with care needs and their immediate environment.

SAR WGG has described what **quality of life** implies in its Comprehensive Care and Support Vision Statement. This is reproduced in this sidebar.

Comprehensive care and support aims to secure a high **quality of life** for every citizen by offering care and support that enables all to take care of themselves at any time in their lives, to connect with their social environment and maintain control over their lives with a view to optimising well-being and health. Comprehensive care and support aims for quality care and personalised support.

Placing quality of life at the centre means that our starting point is a **holistic concept of the human person. Mental, physical, social, ecological and spiritual aspects of the human being must always be approached in a coherent way.** Internationally, we find this vision of the person back in the ecobiopsychosocial model. (CCS Vision Statement, p. 14)

Quality of life is reflected among others in **the pursuit of the best possible functioning of the person with care needs in the community and in the ability to participate in society.**

These objectives transcend the different sectors and allow the well-being and health sectors to work together in an integrated way. Optimal functioning and participation are indeed important objectives for all citizens, with or without care and/or support needs, that greatly contribute to the quality of life.

A recent report by the Dutch healthcare institute Zorginstituut Nederland (2015, p. 14) takes the **functioning of the citizen as central starting point**. The report, 'Naar nieuwe zorg en zorgberoepen: de contouren' [Towards new care and care professions: The contours], asserts that *functioning means that people are able to live the life they want to lead as much as possible. This comprises physical, psychological and social functioning.*

The latter refers to the **ecobiopsychosocial model**, which is an extension of a medical model of human functioning that not only focuses on biomedical aspects but also on psychological and social factors that help determine illness and the process of healing.

We draw **your attention to two elements in particular**. Using a holistic or generalist approach, we must always view the person in his or her totality with respect to both health and well-being. In so doing, people are defined not only as a biological, psychological and social being, but also as an **ecological and existential being**.

■ The **existential component, the 'experience of being'** of the person, is essential for providing comprehensive care and support. People indeed should be able to lead the lives they want to live, but a person is a 'searching being'. What is this life that the other wishes to lead? What is at stake for him or her? This existential component makes it very important that care and support be directed at people as they are today, with all their worries, doubts, hopes and desires.

■ We also note that functioning not only has an individual component, but also collective and contextual components. This is **the person as ecological being**, the person in his or her (social) environment.

- With respect to one's own network, this means among others that the person functions well within the connections he has and the relationships he maintains. Dysfunction in humans often has to do with the problems related to connecting with others.
- At the level of society, we also see that limitations in functioning can often be avoided or reduced by adapting the environment. A simple but telling example related to mobility: providing accessible sidewalks by making them wide enough and modifying the curbs. Such modifications focus on the functioning, not on the limitation of one target group. The elderly who have difficulty walking, those who require a wheelchair, bicycling young children as well as parents with strollers will be able to move about more easily thanks to these.

Focus on function in fact is based on the possibilities of people and how these can be best supported (Zorginstituut Nederland, 2015, p. 19). In this

sense, adaptations that ensure that as many citizens as possible can **participate** (education, work, sports, culture etc.) are **essential to the quality of life in a society**. This places care and support (back) in a broader perspective. The paradigm shift must be made not only in the 'care and support' system. At the same time, we must ask ourselves if we are setting the right priorities in society for the domains of education, work, housing, social protection and well-being, local policy ...².

1.3. Seeking answers

Although all social systems (care and support, education ...) sought answers to the growing complexity of society, today we must admit that we're stuck, that many answers of recent decades may not be the right answers (any more).

1.3.1. A more generalist approach needed

The demands of citizens and those with care needs have been also changed significantly. The evolution towards more chronic problems and multimorbidity is not unrelated to this. Care and support issues are not always technologically complex and highly acute. They often are also issues of daily life (family, education, work-related stress, ageing, the experience of loss, administrative problems ...). The complexity here is of a different order. The complexity is in the context, in relationships (or the lack thereof), in bringing together informal and formal care in order to arrive at custom care³. This context-complexity also means that the issues and needs are simultaneously present in multiple areas of life. Zorginstituut Nederland (2015, p. 32) notes that *solutions can also be found in the context that are scarcely used if used at all (education, housing, security and safety, sports facilities, infrastructure)*.

There are no standard solutions to these complex problems. The complex questions that are specific to each individual usually cannot be adequately answered from a specialist or unidisciplinary approach. They also require a **generalist approach** by professionals who, in the context of the person with care needs, are able to contribute in a tailored way to treatments or solutions in the areas of life where this is necessary and desirable.

² SAR WGG therefore fully supports the choice of the IMC to include in the plan of action for integrated care for the chronically ill, 'job preservation, socio-professional and socio-educational reintegration' as one of the 18 components necessary for the development of integrated care.

³ This idea is also found in the definition that the EXPH (Expert Panel on Effective Ways of Investing in Health) gave to Primary Care (2014, p. 18). The Expert Panel considers that primary care is *the provision of universally accessible, person-centred, comprehensive health and community services provided by a team of professionals accountable for addressing a large majority of personal health needs. These services are delivered in a sustained partnership with patients and informal caregivers, in the context of family and community, and play a central role in the overall coordination and continuity of people's care.*

A generalist approach also implies a strong preventive function. Prevention includes all initiatives that deliberately and systematically prevents a problem and aims to promote quality of life. A feature of generalism after all is that not only are 'cure' and 'care' used, but also prevention and health promotion. This concerns primary, secondary as well as tertiary prevention⁴.

A more recent policy trend with great impact on the care and support sectors can be expressed with the term '**socialisation**'. For SAR WGG, socialisation can and must be understood as it is described below (see sidebar).

Socialisation of care is a shift in care that aims to allow those with disabilities (physical, mental or psychological), the chronically ill, vulnerable elderly, youth with behavioural and emotional problems, those living in poverty ... with all their possibilities and vulnerabilities, to take up their own meaningful place in society, to support them as much as possible, and to allow the care to be integrated into the community to the extent possible. Concepts that play a role include deinstitutionalisation, community care, empowerment, a strength and context-oriented approach, managing demand and respite care (SAR WGG, CCS Vision Statement, p. 8).

This trend gives shape to an important **cultural change** in how we look at handicap and disability, at care and support, at recovery and at empowering people. It calls for greater cooperation between different organisations and sectors *and* between care and support professionals and people with care and support needs (Hermans, K. et al, 2009, p.2).

Socialisation properly understood can counteract the tendency to approach problems in an exclusively specialist way by better embedding them, via a generalist approach, in the environment of the person with care needs.

⁴ The Board describes the various forms of prevention in the primary care discussion paper (4 November 2010).

1.3.2. Connectedness as a precondition for autonomy

We think it is important to also reflect on the question whether citizens and/or those with care needs are best served by an individual approach or a relational approach to care and support. Does comprehensive care and support mean that we focus on the individual, on the person with care needs and the goals he or she sets, or does comprehensive care and support in the first place arise of the connections - or possible restoration or creation of these connections - which the person with care needs has with his or her surroundings?

In other words, should care and support be based on an individualistic approach, *the* achievement of our time, or should care and support go further and in the future, concentrate more on connecting people? This assumes that people need connections as a precondition for autonomy and self-determination, as a precondition for participation in society.

In the eyes of the Board, autonomy can't be separated from connectedness.

Taking a personal and needs-driven model as point of departure after all does not mean calling into question the solidarity mechanisms at the level of society. It is necessary that a solidarity framework exists in society in which professionals and citizens can shape a care and support relationship. The Board refers to the *Triple Aim* framework that aims at efficiency in care. The WHO's ⁵*Five-Star Doctor* also questions how the aspirations of citizens and the resources available in the community can be linked.

In this, society's perceptions of care and support are also important. In a solidary society, citizens realize that collective resources are not inexhaustible and should be used efficiently. Citizens are also aware of their responsibilities and of the importance of caring for one another. This by no means excludes person-oriented and needs-based care and support. It is a plea for finding a good balance.

Comprehensive care and support is indeed a story about the **quality of living together**.

Below we will see that the choice of the term 'person with care needs' or 'citizen' colours the debate.

⁵ Boelen C (1997). The Five-Star Doctor: An asset to health care reform? Available at: www.who.int/hrh/en/HRDJ_1_1_02.pdf

1.4. The person with care needs and the citizen

The use of terms is important because of the human vision behind them. We wish to further explain this here.

Person with care needs

In the CCS Vision Statement, we used the term 'person with care needs'. We meant by this the **“person with care and support needs and his or her immediate surroundings”**. The choice of these terms were deliberate. The Board reiterates its preference for this choice, for several reasons.

- The use of certain terminology is often associated with a context. In a hospital or with the doctor we spontaneously talk about the patient, in the welfare sector, the term user or client is prevalent, or persons with care needs can be referred to as the elderly, families or young people. None of these terms 'work' outside their own context. In a hospital, it is strange to speak of a client; in a welfare context it is unthinkable to speak of a patient. Therefore SAR WGG advocates a more **overarching term** that transcends each of the contexts and sectors.
- Recently, various corners have argued for use of the term 'client'⁶. For SAR WGG, however, there is an essential difference between use of the word 'client' - whose starting point is the perspective of supply - and a 'person with care needs', whose point of departure is a **user or needs perspective**.
- Moreover, we do not wish to reduce the person with care needs to his or her illness, disability or problem, but in the first place to treat him or her as a **person** who needs care or support. The use of the word 'person' refers to the **holistic concept of the person** that is our point of departure. The existential nature of the person is important to comprehensive care and support. We, after all, are not just patients, customers or clients.
- The term 'person with care and support needs and his or her immediate surroundings' refers to the **link** the person with care needs has with the surroundings in which he or she lives.

For these reasons, the Board reaffirms its decision to use the term 'person with care needs'. And, in an even broader societal perspective, the Board will also use the term 'citizen'.

⁶ See Comments on Herman Nys' final report 'Slimmere zorg 2014' [More intelligent care 2014], the conference 'slimmer zorgen voor morgen' [more intelligent care for the future] 2013. (p. 12); Bernadette Van Den Heuvel (2014) *Netwerkzorg* [Network Care]. Acco.

Citizen

The term 'citizen' is consistent with the Board's vision on socialisation, inclusion, functioning in, living in and participating in society.

- The term 'citizen' transcends the care and support system and places the focus **not only on the person with care needs, but also** on the **healthy citizen** who, among others - through prevention and information on healthy behaviour - must be included in the 'quality of life' story.
- It's also clear that **entitlement to care and support** is derived from the fact that one is a citizen. The inclusion movement for persons with disabilities and the recovery and rehabilitation idea for people with mental health problems start from the same civil rights approach. Each citizen, on the basis of his or her citizenship, is entitled to a meaningful place in society. *Inclusion is indeed achieved when all citizens are included in and belong to a community, depending on who they are and may be. One thereby starts from a position of equality, anti-discrimination and the added value of diversity, and society is adapted to the individual rather than the individual to society*⁷.
- The citizenship approach also pays **greater attention to other societal systems in which a person with care needs moves, which are equally essential to his or her quality of life**. After all, *as more people with a chronic illness [persons in need of care] continue to play an active role as citizen or worker, comprehensive care [and support] becomes more a matter for all of society. From the perspective of the chronically ill person [person in need of care], comprehensive care approaches his or her **life and well-being as a full-fledged citizen**, notwithstanding the limitations entailed by chronic illness [or care needs] (Ch. Van Audenhove, 2015 p. 27).*
- By the word 'citizen', we also understand those who provide care (family caregiver, volunteer caregiver ...). After all, as citizens we all will need care and support at certain times, in one way or another, for ourselves or for someone else.

We have opted for the territorial concept of citizenship: someone who is in a particular territorial area at a particular moment, and derives rights and obligations from this. By the concept of citizen we understand not a purely individual approach to rights and obligations, but rather **a story of 'civility' as a universally binding ideal within a socially meaningful framework** (see Antonovsky in van Ewijk & Kunneman (eds.) p. 2015. 53).

We will use both terms in this document. When talking about care and support, we will use the term 'person with care needs'. We will use the term 'citizen' when it concerns society at large.

⁷ GRIP website

2. What do we expect of the professional?

In this chapter we first define the concepts ‘care and support professional’ and ‘generalist competency’. We then describe what we expect of professionals in the light of comprehensive care and support. What is the essence of professional activity?

2.1. The care and support professional

Professional

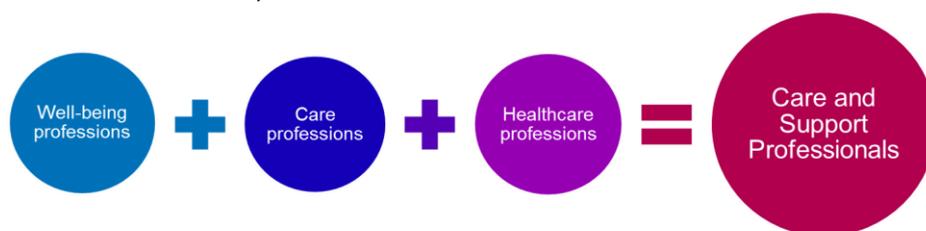
In order to focus the attention of all professions and professional groups on the **essence of professional activity**, in this text the board has opted to use the term ‘professional’.

Van Ewijk states that a *professional* stands for a *qualified worker who works primarily in complex, chaotic contexts in which much comes down to their own judgements and actions.* (Van Ewijk H. & Kunneman H., 2015, p.19).

The essence of professional work, of professionalism, is that each care and support system finally refers back the unique encounter between those who need care and support, and those who are entrusted with delivering such. This trust is earned by a special blend of technical competence and a focus on service and presence, backed by an ethical commitment and social accountability (Frenk J. et al, 2010, p. 1925).

Care and support professionals

The board chooses to use the term ‘care and support professionals’ to designate all professions in the health and well-being sectors (health policy, well-being *and* family) that play a role in the care and support of people with care needs, regardless of the division of competence in this country. Thus with this term we refer to healthcare professions (federal matter) as well as the health and well-being professions (competence of the federal states).



The Comprehensive Care and Support Vision Statement stated that the umbrella term ‘comprehensive care and support’ also includes self-care and informal care (family caregiving and volunteer caregiving). Care and support professionals are responsible for the **formal care and support** within comprehensive care and support (= professional care and support).

2.2. Generalist competencies

When describing what we expect of the care and support professionals, competencies are of central importance. Properly preparing future professionals (developing competencies, lifelong learning) will be crucial to meeting the expectations. The care and support system is only as good as the quality of its professionals.

The Board subscribes to the **major importance of personnel with a good technical or specialist background**. A person with care needs absolutely requires care and support that meets the quality requirements placed by society and science. Specialist care is essential to this. In this document, however, more focus will be given to the generalist competencies of professionals. They are essential in the context of comprehensive care and support, but in the pursuit of highly technological and specialised professional knowledge and expertise, they are all too often wrongly pushed to the background.

Although we will not only focus on the competencies that a person needs - in this exercise we will examine the **conditions** that make it possible for professionals to provide good comprehensive care and support ⁸ - it is nevertheless important to provide a few definitions.

■ Competency

- There are many definitions of competencies. What is found in most definitions is that a competency is a combination of an individual's knowledge, skills and attitudes. [...] With respect to the work context, a competency could be considered as the individual capacity to use knowledge, skills and attitudes integrated into the activity, depending on the concrete and daily work situation. Thus, a competency that is used in the workplace is visible in the actual conduct of the individual employee⁹.
- **Attitudes** play a crucial role in the competence of the care and support professional. The interplay of attitudes with knowledge and skills determines why someone does what he or she does. We aim to describe not so much what a care and support **professional** must 'do', but **what or who he or she must 'be'**.

⁸ This will especially be further elaborated in Part 2.

⁹ <http://www.competentindesocialprofit.be/?cid=1&pagina=103-wat-zijn-competenties>

- **Generalist competencies**¹⁰ are those competencies that require a professional to provide care and support based on a generalist strategy or approach. A generalist approach implies that a varied palette of approaches and strategies could be used to address a broad range of unspecified health and/or well-being (related) problems.

Generalist competencies are complementary to specialised (often technical) competencies. We deliberately do not speak of ‘the generalist’ or ‘the specialist’. The focus is on competencies, and not on ‘professional groups’ that we wish to pit against one another. A ‘specialist’ must indeed have generalist competencies. Within a generalist strategy or approach, specialists can also find their place in contributing to the handling of specific complex problems.

¹⁰ We make a distinction between core competencies and generic competencies.

- Core competencies are competencies that each individual needs in light of self-fulfilment and development, of active citizenship, social inclusion and employment, such as mastering one’s mother tongue, mathematical skills, digital literacy, social and civic competencies ... They are important in diverse sectors.
- Generic competencies point to general skills such as the ability to report, observe, etc.

2.3. The essence of professional activity in care and support

What do we expect of professionals in the light of comprehensive care and support? **Comprehensive care and support is the context in which generalist competencies find their place.** We will resume and will further elaborate some elements of this context (see also the CCS Vision Statement, 7 December 2012). The intent here is not to describe all the generalist competencies in detail.

2.3.1. Quality of life as the aim of the care and support relationship

Comprehensive care and support focuses on quality of life. Taking this as starting point brings about a **real shift in what we expect of professionals, in the way they enter into a care and support relationship.** Professionals should focus more on functioning, while paying attention to what is really important to the person with care needs, and through information and consultation with the person with care needs, find the most appropriate solution or treatment.

With quality of life as a central notion of comprehensive care and support, our care model stands for the challenge of making a paradigm shift from problem-oriented to goal-oriented care and support. It therefore also implies a **shift from supply-driven to demand or need-based care and support.**

In a problem-oriented (or disease-oriented) model, we aim to tackle the problem and/or issues with the available supply. There is a risk here of overlooking **that which is really important for many people with care needs**, namely the extent to which they (still or again) **are able to function and participate in social life.** The quest for full-fledged citizenship for people with disabilities, and the recovery and rehabilitation idea for people with mental health problems, are movements that earlier gave priority to quality of life (see inclusive society).

With a goal-oriented care and support model, listening to the requests and needs of the person with care needs is central. The requests are clarified and articulated in the context of the social environment. One therefore will also spontaneously give more attention to and allow room for the support of the person's own abilities (**empowerment**) to deal with the problems. If possible, the person with care needs will be assisted by his or her environment and, if necessary by professionals, in order to maintain or acquire a good quality of life and to achieve his or her self-determined goals. With goal-oriented care and support, it is also the persons with care needs themselves - not the professional - who evaluate whether or not their goals have been achieved, (CCS Vision Statement, p. 14).

Focusing on functioning

We expect professionals to provide care and support which is focused on supporting people with care needs (and their immediate environment) in their functioning and living as well as in their participation in society.

Placing the focus on functioning and participation presupposes that the professional is not restricted to a narrow focus on a disease, disability or a problem, but pays attention to its impact on the functioning of the person with care needs (and his or her immediate environment). It is not the cause of the need for care (age, disability, chronic disease, socio-economic vulnerability,...) that is important, but rather the question concerning what can be done to function as effectively as possible, i.e. **to function better, to restore functioning or prevent a worsening** and to participate as much as possible in society. A focus on the illness, the disability or problem can sometimes be necessary, but a person may not be reduced to his or her illness, disability or problem.

Goossensen and Baart (2001, p.5) argue that although we cannot escape reduction, and in a sense this is also needed in an information complex environment, the danger lies in taking reductions for truth. What is harmful is a lack of open and constant attention, a lack of desire to optimally adjust one's own conceptualisation to do justice to the other. Moreover, lack of time, a dominant culture or a too task or problem-oriented attitude promote such reduction.

Zorginstituut Nederland states that *other requirements will be placed on the healthcare professional of the future. He or she will need to be able **to determine the demand for care from the perspective of the functioning of the citizen**. The needed care should contribute to the functioning of the citizen. [...] This also means 'not treating if this does not contribute to the functioning'* (Zorginstituut Nederland, 2015, p. 32).

This makes it very important to take into account the perspective of the person with care needs in the care and support relationship. Care and support requests should always be listened to in the context of the social environment of citizens, and approached in a goal-oriented (and not a problem-oriented) way. Professionals are tasked with redirecting diagnosis-oriented care (based on the biomedical model) to **goal-oriented care and support** that concerns (better) functioning. People's goals are dynamic. They evolve throughout a person's life. Goal-oriented care and support means taking this variability into account.

When healing or the full recovery is not possible, the values and beliefs of the person with care needs become all the more important for the choices made in care and support. Goal-oriented care and support, however, must not be misinterpreted as the 'customer is a king' or 'you ask, we deliver'. It concerns the interaction between the goals of the person with care needs and the expertise of the professional.

Paying attention to what really matters

In essence, the requests and needs of the citizens should drive the services and not vice versa. We do not mean by this that every request, requirement or need by definition must be fulfilled, but rather that they are the starting point around which the care and support is organised. We therefore speak of **'request-oriented and need-oriented'** and not 'demand-driven'.

Request-oriented and demand-oriented care and support concern a generalist approach to **obtaining insight into what is really important for the person with care needs**. Lon Holtzer, the Flemish care ambassador, refers in a recent book *De 7 privileges van de zorg [The seven privileges of care]* (2015, p. 42) to 'four questions for wisdom' by the philosopher Hegel. These four questions allow us to approach a care situation from a generalist perspective.

- What happened to you? Who are you? (context)
- What are your vulnerabilities and what is your resilience?
- Where do you want to go? (goals)
- What do you need? (needs)

These questions invite *authentic and sincere listening*. They should form the basic principle and starting point of every encounter, of every care and support trajectory travelled by a person with care needs with his immediate environment and the professional care and support providers.

- The first question invites the person with care needs to tell his or her story and to sketch the context.
- The question concerning vulnerability and resilience examines the capacity, the limitations and capabilities of the person and his or her immediate environment. It is about empowerment, autonomy and addressing the powers inherent in the person with care needs and his or her environment.
- Formulating goals makes possible the real shift from problem-oriented to goal-oriented care and support.
- When the (life) goals and the vulnerabilities and capabilities of a person are clear, the needs someone has will also become clear.

It is evident that not every care situation lends itself to first fully exploring these questions with the person with care needs. An acute health problem requires immediate care. Yet it still concerns the four reference questions that are the starting point for every contact in care and support. They must be dealt with in one way or another. *Why is / this person / coming / now / with this question / to this professional?*

It must be a **fundamental attitude** of every professional to always take into consideration how you as professional comport yourself in the care and support relationship and thereby includes the four elements outlined above. The professional must have acquired methods to answer these questions from a sincere and committed attitude with respect to the person with care needs.

This fundamental attitude refers to the actions of the professionals and to how these actions are experienced. The **presence theory** (Baart A., 2001) in essence focuses on this. What can the professional be and mean for the other? This is not established beforehand in routines, protocols and standards. It will also not be dealt with quickly via a short intake interview. It concerns **exploring what you can mean to the other based on an attentive presence**. The methodological characteristics of presence include aspects that connect strongly to the holistic and generalist approach to the person with care needs. *The presence practitioner moves 'towards the other' rather than vice versa. He is not merely accessible for just one type of problem or request for help. Key-words are openness, domain transcendence, versatility [...] specialising in the unspecialised. In the 'connection' with the other, one will not only try to solve the problems, but finding a satisfactory relationship to life is foremost* (Baart A. & Grypdonck M., 2008, pp. 21-26).

The website [beroepshoudingindezorg.nl](http://www.beroepshoudingindezorg.nl)¹¹ states that *the professional attitude makes visible the moral sensitivity of the professional, and shows the values and norms on the basis of which he is providing care. Ideally this is done in the care relationship. 'How can I do what is good for the other (and for myself, so that I can continue to function optimally)?'*

In order to do what is good for the other, it is necessary for the professional to dare to call into question his own norms and values and those of the other. He must be also prepared to take a critical look at the norms and values of the (bureaucratic, organisational or economic) environment in which he encounters the other. (What do I do if I see that the care recipient has trouble with some 'house rules'?)

We expect a care and support professional to focus on presence and be able to reflect on his or her own actions. Questions such as 'how am I doing?', 'am I able to look at myself in the mirror' obviously are a part of professional activity. We expect a professional to be able to refrain from taking his or her own frame of reference as the standard for judging the quality of life of the other'.

It will be a challenge to rewrite the role that professionals precisely can and must play in the directly accessible services on offer. It is no longer just the professional who diagnoses and/or treats the problem. These are the goals of the person with care needs that will determine the content of the care and support, in an **equal** relationship between the person with care needs and the professional. (CCS Vision Statement, p. 17)

Inform, consult and support autonomy

Professionals have considerable - often discipline-related - technical information and expertise. Often there is a power imbalance in the care relationship because of the information asymmetry and because the person with care needs has a request that has to be addressed.

With quality of life as the focus of care and support, the classical (paternalistic) idea that a professional alone makes the diagnosis or draws up the problem analysis and thereby proposes the treatment or

¹¹ <http://www.beroepshoudingindezorg.nl/index.html>

solutions, with the professional 'knowing what is best for the person with care needs', is usually no longer accepted. The person with care needs wishes to participate in his or her own care and support, and wishes to keep control in their own hands. The goals of the person with care needs should be able to help determine the content of care and support.

In order to increase the participation of the person with care needs, the professional (and his or her team) and the person with care needs (and his or her immediate environment) must therefore enter into a **care and support relationship** which is **based on equality and respect for autonomy**. Consultation *is essential if we wish to respect a patient's autonomy and enable him to make well-considered choices in an informed way*¹².

*In the participation model, doctor and patient share power and responsibility, and patients are seen as **active care users**. They are entitled to full information, should be treated with respect, and must be actively involved in decisions concerning treatment. In short, the consultation is more person-oriented than physician-oriented. [...] Person-oriented consultations are based on recognition of the importance of the needs and preferences of the patient. Cooperation prevails. Within this partnership, the physician has scientific knowledge, while the patient mainly has experiential knowledge.*

Making choices in a participatory manner according to a consultative model (shared decision making) requires **new conversation skills** for which health care providers in training have too few role models. We believe that a further rapprochement between health and well-being actors can certainly also be beneficial here. A context and client-oriented approach is one of the basic skills of generalist social workers. Request clarification is one proven method. *Some professionals in a multidisciplinary or in a transdisciplinary team work mainly from a consultative model: social workers, psychologists. They can be good catalysts in spreading the culture and the skills.*

In the **primary care discussion paper** (4 November 2010, p.5), the Board wrote that the relationship of the person with care needs and the professional must be based on an **equality** through which good care is obtained together. It may be **'negotiated'** or **'participatory' care and support**, where the advantages and disadvantages of problem-oriented and goal-oriented care and support must be weighed against one another, while it is the person with care needs who keeps control and takes the final decision.

Especially in the field of healthcare, the (medically) technically trained professional must leave his or comfort zone a bit. He must be prepared to live with his doubts and dare to put this on the table. A professional is no longer 'the one who should know' but someone who, in consultation, contributes his or her medical technical expertise in order to work together to find the best treatment for the person with care needs. In the case of clear problems where it has been proven that a specific treatment or therapy gives the best results, the professional must use his or her expertise to guide the person with care needs, and point out the consequences if the treatment is not followed.

¹² The quotes in this part were borrowed from Van Audenhove Ch. (2015) pp. 9, 33-34; 55; 106.

However, when it comes to complex problems, with several equivalent treatments, other competencies must be called upon. Informing and consulting in order to arrive at an informed choice on the part of the person with care needs. Information, consultation and **coaching** the person with care needs will help ensure his or her active role in the care process. We will come back to this in the next point.

*While informing patients but not guiding them in making choices can allow them to make their own choices, this is not a person-oriented care. Most patients, after all, also wish to be supported by their doctor when they need to take important decisions. In addition to standard information, they also need tailored information and guidance in order to take decisions and be satisfied with their choices. To truly give autonomous decision-making a chance, it is important to **support the autonomy of the patient**, as it happens in a person-oriented approach.*

Strengthening participation and inclusion

When discussing the care and support relationship, we described above the importance of including the perspective of the person with care needs in the care and support relationship, of actively involving the person with care needs and allowing him or her to participate. This collaboration is crucial to the success of comprehensive care and support.

In addition to participation in the care and support itself, the **participation** of people with care needs **in society** - by including civic roles as worker, parent, student or volunteer - is often essential to the quality of life. The Board emphasises that work and (adult) education are important levers in **realising inclusion**. We brought this to your attention above in section 1.2 (quality of life). Using this as starting point also requires other attitudes on the part of professionals. The professional must start from the functioning and the goals of the person with care needs, and start from the question concerning what someone can mean for society, start from the question of how someone with his capabilities 'can take up his own meaningful place in society' (see definition of socialisation). Succeeding in this represents a real step towards inclusion.

Direct (policy) participation by persons with care needs (and their families) at the level of organisations, in partnerships, at policy level and in research and education must become much more self-evident. Professionals will also need to be trained and sensitised in order to begin working with this new partner in care and support.

2.3.2. Supporting self-care

Self-care is learned and purposeful behaviour that comprises all decisions and actions that people take in their everyday lives to meet their basic needs, to ensure their development and **to regulate their functioning**. By capability of self-care is meant the degree to which a person is capable or proficient at self-care.

The required self-care - what it takes to live well, to develop and stay healthy - was described by Dorothea Orem in 1971 in the form of three goals.

1. First, the universal care needs of a person must be fulfilled. These are needs that apply to every person, such as the sufficient intake of air, liquids and food, adequate hygiene, a good balance between activity and rest, between seclusion and social interaction.
2. The second goal of self-care is fulfilling self-care needs related to development, such as coping mechanisms and the skills to adapt.
3. Finally, there are self-care needs associated with illness, disability or treatment such as identifying symptoms and treatment effects, ensuring adequate medical assistance, the effective implementation of medical prescriptions, and the necessary change to self-image or lifestyle.

Self-care needs are universal, for both primary care and development needs. Illness, chronic conditions and limitations may well bring specific self-care needs with them.

The ability to engage in self-care can vary from individual to individual. A disability or a chronic illness can result in a reduced ability to engage in self-care. A child growing up in a less favourable environment invariably has also received fewer opportunities for development. For that reason, this vulnerable group often has a diminished or limited ability for self-care.

The three goals of self-care that Orem describes show that self-care concerns every citizen and is about well-being *and* health. Self-care doesn't only include people in need of care. We all take care of ourselves with a view toward a good quality of life, with a view towards maximising well-being and health. Moreover, in the case of self-care, it is not just about self-reliance in the area of ADL and IADL¹³, but also the care for one's own development and social functioning (Van Ewijk, 2010, see also sidebar, section 1.1).

When the ability to engage in self-care and the self-care needs are not in balance, we can speak of a self-care deficit. In the case of a self-care deficit, one is temporarily or permanently unable to care for oneself. **Care and support professionals** will try to cover this self-care deficit. They must also be alert for the response and detection of unreported self-care deficits. In the pursuit of the best possible quality of life, it is also

¹³ ADL, Activities of Daily Living, such as eating waking up, going to sleep, washing, dressing, toilet use; IADL, Instrumental Activities of Daily Living, such as preparing meals, shopping, doing laundry and housework, making phone calls, using public transport, managing one's own finances and administration. In the case of deficits in self-care, these tasks are often covered by family caregiving and professional residential care (often home care). (see Masuy A.J., Steunbeleid voor mantelzorgers in België: een typische Belgische ontwikkeling [Policy support for family caregivers in Belgium: A typically Belgian development]. In: Belgisch Tijdschrift voor de SZ, 1st trim., 2010 volume 52, pp. 57-79.)

important that - as far as possible - the existing capability for self-care is supported and further developed.

Self-care, after all, requires specific competencies. We believe that a society has a responsibility **to maximally support each person in developing this ability for self-care** (or competency to engage in self-care). This is an **exponent of socialisation**. The Board has made many concrete proposals to support self-care in the Primary Care Discussion Paper (4 November 2010, p. 8-10). At the same time, more needs to be done in the area of **prevention and promoting healthy behaviour**. This is not only a task for the health and welfare system. *Promoting healthy behaviour should take place everywhere: in healthcare, in schools, at work and in the neighbourhood (Zorginstituut Nederland, 2015)*.

Self-management is a term that is originated in healthcare, in the chronic care model. Self-management concerns intentionally taking decisions oneself about planning and implementing self-care activities in order to fit the illness into daily life and to deal with the consequences of the illness (Dorn et al, 2007, pg.12). Effective self-management includes the ability to monitor one's own condition and to generate the cognitive, behavioural and emotional responses which are required for the maintenance of a quality of life and patient satisfaction (Lechner L., Mesters I. & Bolman C., 2010, pg. 221).

Self-care and self-management make many demands on citizens. An active attitude and a willingness to take responsibility for certain self-care tasks are a part of this. In care and support situations, we expect people with care needs to have significant levels of knowledge, skills and abilities in order to play a more active role in care.

All the initiatives and activities undertaken to equip citizens for this fall under the term of **empowerment**. Empowerment means **guiding people**, strengthening them and making them 'competent' so that ultimately they can make their own choices. We emphasise **that empowerment means much more than providing information** on 'how to take health into one's own hands'. The way of real empowerment of the people with care needs, to make them 'competent' and to bring about lasting changes in behaviour, better support by the professional care and support system is needed. Professionals must be adequately equipped to guide this process. They are expected to coach the person with care needs to be an active participant in the care and support process.

In this, professionals must provide information, motivate to live healthily and to faithfully continue treatment, and must help people with care needs develop the behavioural skills to take upon themselves their own care at home. *Helping people gain control of and improve their health within person-oriented care is an important aspect of every consultation (Van Audenhove, 2015, p.39)*.

In short, the **professional** plays a crucial role in **strengthening the capability for self-care and self-management in the person with care needs**.

We do point out that it is a mistake to situate empowerment only at the individual level and to re-translate it as an increase in individual responsibility (the so-called individual bias). Empowerment is a multi-layered concept that is also situated at the collective level. We discuss this in section 2.3.4.

Finally, we have one more **important comment** to make. Today many people with care needs wish to be an active and informed participant in their own care and support process. A vision of care and support based on quality of life assumes that people want

to maintain control over their own lives. We stated that citizens must be maximally supported in taking up this role. Yet we know that - even when society places a strong focus on empowering citizens - there are always people who are less articulate, who are not actively looking for information or who are unwilling to do so. So we know that not every citizen will always be able or willing to actively participate. Therefore, the comprehensive care and support story must pay special attention to those with care needs who, whether temporarily or not, are unable, or don't wish to take on the management thereof.

People with care needs after all differ significantly from one another. Educational level, socio-economic status, age, cultural background and other variables help determine the image one has of his or her role and share in a care and support process. **Working on the image of care and support** at the level of the whole of society is certainly an important aspect in exerting some influence on this.

In addition, however, we must ensure that the care and support system not only focuses on the active, well-informed person with care needs, but that this focus is also broad enough to cover all types of citizens. Care and support must be tailored to the person with care needs. People, who require more guidance and support to achieve equivalent care, must receive such.

2.3.3. Sharing care and support with family caregivers

Professional care and support must take as its starting point the preventive notion that support and guidance of self-care and informal care is necessary (CCS Vision Statement, p. 15).

Informal care consists of non-organised family caregiving (the personal network of the person with care needs) and organised informal care (such as volunteer work). Here the focus is on the family caregiver.

Informal care and formal care and support must form a continuum based on the concept of subsidiarity and complementarity (see sidebar). This means providing all possible opportunities (*and* support) to the least intrusive forms of care and support based on socialisation properly understood¹⁴.

¹⁴ According to the definition given in section 1.3.1

In any care relationship, the professional must take into account the available family care and involve this in the care and support process. Indeed, when specialised care and support is needed, the aim is to provide this in consultation with family caregivers, with attention being paid to the support available from the immediate surroundings, and whether and how care and support for the person with care needs can be returned to the home situation. Hence, from the outset, professionals must be thoroughly committed to sharing this care and support with family caregivers. In this, the professional must consider the capacity of the family caregiver and provide the necessary support for this.

We note that in the story of comprehensive care and support, particular attention must be also given to persons with care needs who don't have adequate family care.

When organising a **continuum of informal care to formal care** and support, the Board recommends use of the concept of subsidiarity, or multi-layered care: from self-care, through family care and neighbourhood care, to professional primary care and specialised care and support. Subsidiarity in this context means **taking advantage of all opportunities to provide self-care, family care and informal care, and supporting this professionally**. This means giving priority to the least intrusive forms of care and support: minimal care provided by the informal network where possible, more intensive formal care and support where necessary. When more specialised forms of care and support are needed, these will be maintained no longer than necessary for the recovery of the person with care needs. The Board stresses that this involves an interplay between the various forms of care and support. Informal care must always be a free choice. Supporting and supplementing this informal care with other forms of care and support will also make this more feasible in many cases. 'The objective is **shared care and support** tailored to the person with care needs, which does not automatically mean making maximum use of all available options. Multi-layered care promotes the autonomy of the person with care needs and avoids dependency on care' (Everaert S., Scheerder G., De Coster I. and Van Audenhove Ch., 2007, p. 14). (CCS Vision Statement, p. 15)

2.3.4. Strengthening social cohesion

Functioning well in society and building a good quality of life often proves easier for those who have sufficient social capital and thus can develop a strong social network. Moreover, social cohesion in society is the glue that makes possible the socialisation of care and support.

A structural strengthening of social cohesion is needed. This could be done at individual level, group level and the level of society at large.

The professional must strive for 'connection' in his or her individual care or assistance. This can be done by checking whether there are people around the person with care needs who can help, by examining the existing social network. A person with care needs can sometimes also be further aided by connections with groups. Proven methodologies exist to appeal to and activate strengthening and restorative actions for per-

sons with care needs (such as family group conferences and family guided decision making conferences).

Professionals can also work on social cohesion at the level of groups (neighbourhoods, communities, etc.). This is an important aspect of **empowering** vulnerable citizens. Empowerment is aimed at strengthening people in vulnerable positions in order to retain or acquire control over their lives. ***The misconception exists that empowerment is only situated at the individual level and to re-translate this into increasing individual accountability (the so-called individual bias). Empowerment is a multi-layered concept in which the individual well-being of persons and groups is inextricably linked to the broader social and political context. It is about shared responsibility that is far removed from the idea of individualisation (Van Regenmortel T. 2007, p. 7).***

Thus empowerment must also take into account the environment. A person with care needs can appeal to his or her immediate environment (family care, the community, the care and support system, etc.). Empowerment also means that action at the political-social level is undertaken to support self-care, self-management, family caregiving and volunteer caregiving (e.g. providing information, breaking taboos, improving accessibility to services ...). We can call this a **process of enabling**: enabling a 'transfer of power' in care and support where the person with care needs is given the tools to retain control over their lives.

Important here is a societal commitment to early, less radical interventions in which professional support can give more attention to **social cohesion, avoiding problems, prevention, and promoting health and well-being**. The actors in social work and social cultural work who already play a connecting role can make an important contribution to a caring society (CCS Vision Statement, p. 15).

In addition, a greater focus is needed on the relationship of professionals to peer support, community health workers, buddies and so on. These are new forms of support that can strengthen the link between professional expertise and experience on the ground.

Finally, we know that the existence of a **quality and accessible care and support system** in a society also contributes to greater social cohesion. An accessible system ensures that people have somewhere to go in the case of problems. This gives citizens the feeling that 'not everything needs to be resolved informally', which is an **important aspect of a proper understanding of socialisation**. International literature also makes it clear that the local availability of comprehensive and accessible care facilities is a critical ingredient of good care (Van Audenhove Ch., 2015, p. 49). Thus, the care and support system itself is an important determinant of comprehensive care and support.

We expect professional care and support in the field to play a **connecting role**. The task of care and support professionals is to activate the existing informal care and support potential in society, and to support and enlarge this where possible. Generalist professionals must also **be able to work in an empowering way**.

In addition, **taking up social accountability** is an important competency. Professionals must ensure that our care and support system meets the requirements of socially responsible care (SAR WGG, Vision Statement on Socially Responsible Care, 24 February 2011).

Young, newly trained professionals encounter a specific system, with specific characteristics and drivers to do certain things and not to do others. We believe that you as professional must also be able to be critical with respect to this system. Is our system working properly? A professional must dare to ask this critical question in order to change the system from within. Frenk et al (2010, p.1923) states that *professionals are falling short on appropriate competencies for effective teamwork, and they are not exercising effective leadership to transform health systems*. Nevertheless, a professional has much information that can be converted into signals. We thus expect professionals to take up this signalling function. An appeal based on social accountability includes among others transcending one's own organisation, participating in the processes in society that can provide structural support to that which the professional is trying to accomplish at individual level. Concretely, this **advocacy** means placing items on the agenda, supporting the organised forces, giving voice to the voiceless, walking side by side with others to realise a change and a better society.

2.3.5. Being sensitive to diversity

Today the theme of 'diversity' is more than ever an issue for society. Professionals are encountering increasingly greater diversity in the workplace. Diversity in care and support means more than mere ethnic and cultural diversity. It also includes socio-economic diversity, language, gender, sexual orientation, etc. . In the context of this advisory document we wish to focus on 'diversity' in the broad sense.

De Maesschalk (2013, p.10) states that *the key to managing diversity is that caregivers [professionals] must be able to work in a 'culturally sensitive' way. This means that one must be aware of the fact that the background of a person - be it cultural, ethnic, social or religious - can play a role in communication, and possibly have an impact on his or her health and healthy behaviour; but this does not have to be the case. This awareness makes it possible to enter into the relationship with the patient/client [person with care needs] in an open and curious way, without falling into the trap of stereotypes and prejudices*.

Our position is that to treat each person equally, regardless of background, also requires in the first place highly developed, directly accessible services. Accessibility is the absence of formal, financial, social and geographical barriers. The various components of accessibility were described by SAR WGG in the Vision Statement on Socially Responsible Care (24 February 2011). Accessible care should be available, timely, accessible, affordable, respect human dignity, integrity and diversity, and be known and understandable (transparent). Thus, within the immediately available services there should be sufficient professionals with generalist training.

Sensitivity to culture

Holtzer (2015, p. 155) states that *culturally sensitive care and support is 'simply' excellent personal, dignified care. [...] Independent of any debate on multiculturalism or diversity, good care means always taking into account the unique, individual person in need of care.*

It is about the fundamental attitude which we previously described with respect to entering into an equivalent care and support relationship. In our view, this fundamental attitude is a necessary but insufficient condition for culturally sensitive care. To truly treat all persons equally, regardless of background, professionals need to develop specific competencies.

The international literature agrees that 'cultural competence' is a necessity for the training of care and support professionals within the current trend towards diversity in society (Hendrickx, 2013, p. 44).

In general, each definition of 'culturally sensitive competence' contains elements of knowledge, skill and attitude.

- The knowledge component involves among others knowledge of cultural schemes, being aware of the great frames of reference in anthropology. Thus one must have some idea of what the rules and relationships are in patriarchal societies, of the impact of religion, and so on. But one must always be aware that not all differences are related to culture. A person's context is also important: the socio-economic position of the person with care needs from a region where conflicts are ongoing, etc.
- The ability to flexibly apply that knowledge is important. *It is important to examine the extent to which the discussion partner [person with care needs] values certain cultural aspects and to what extent this might be an obstacle to the contact. This is to avoid stereotyping, i.e. the individual being reduced to a caricature of the original ethnic group (Hendrickx, 2013, p.46).*
- The right attitude is essential to culturally sensitive competence. The desire to deal with people with a different background must be present. The professional must become aware of his or her own prejudices. It is important that he/she is able to reflect on his/her own background and influences.

Language and time are important aspects of cross-cultural care and support relationships (De Maesschalk, 2013, p.15-17). In providing care and support, one above all must be able to communicate well with one another. Which is why it's necessary to take time, especially at the start of a care and support relationship. Language is also very important: of course it's good that professionals themselves are multilingual, but we emphasise above all the need for more interpreters in care and support (see Part 2: alternative forms of guidance).

International treaties such as the Universal Declaration of Human Rights, the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities are the reference. They represent the ethical minimum for care and support (e.g. equal treatment of men and women). This is true for professionals but also for all citizens, for persons with care needs, the users of the care and support system. Discrimination and prejudices cannot be tolerated by any of the parties.

Culture, however, cannot be an excuse to ignore these rights. Being culturally sensitive means communicating well, learning to know and appreciate the perspective of the person with care needs. In addition, a professional must also indicate what his or her own limits are.

Socio-economic sensitivity

The above factors are applicable equally to the care and support relationship with people from a different socio-economic background. We translate them here to a specific context.

- Knowledge: It is important that professionals understand the structural causes, the mechanisms of poverty, the way exclusion works (WHO, 2008).
- Skills: A professional must then be able to translate these insights into the context of persons with care needs. Attention to and insight into the social codes in underprivileged families is an important skill.
- Attitudes: A professional who works in a 'socio-economically sensitive' way is open to working with people with a different socio-economic background, is aware of 'his or her own frame of reference', and will not take this as the only standard for judging the quality of life of a person with care needs.

2.3.6. Use of Technology and ICT

Technology will play a dominant role in the prevention, diagnosis, support and treatment, and self-management. In 2030, telecare will make it possible for citizens to handle much itself: at home or in the neighbourhood. This will give healthcare professionals a more executive, supervisory and coordinating role. Which can lead to a reduction in the number of specialisations and professions (Zorginstituut Nederland, 2015, p. 22).

Thus technology and digitisation will radically change how we provide care and support. The way in which mobile devices such as smartphones have spread in no time, and the ever growing capabilities of mobile applications (mHealth) suggest that the care and support sector could look very different within a decade. Technology will undoubtedly play a crucial role in healthcare innovation and the ability to do things differently.

If developments in technology and ICT are integrated into the care and support sector in a sustainable way, this too can benefit the emancipation of persons with care needs and support their functioning and participating in society. Sustainability means among other things that technology should be used only when it contributes to quality of life.

The use of ICT to record, structure and encode information will also make a crucial contribution to the integration of care and support. It can support partnerships.

Hence, professionals will need to quickly jump on the digitisation bandwagon. *The new digital world of discoveries in well-being and healthcare, of course, may not become detached from the world of care professionals. That would not only be incredibly inefficient, it would also increase the risks. The two worlds urgently need to come together better (Van Herck P., 2015, p. 90).*

ICT can facilitate and support care and assistance, but attention must continue to be placed on the potential pitfalls. The 'digital divide' brings with it a serious risk of inequality.

2.4. It takes two to tango or the perspective of the professional

We can only be a caring society if there is 'concern and support for the professional'. The Board has already emphasised the importance of supporting informal care, and it believes that due attention should also be given to properly supporting professionals and making it possible for them to do their work. Among professionals it is also very important to maintain a balance between the ability to cope and the size of the burden. The proper organisation of professional care and support should also strengthen the professionals themselves (CCS Vision Statement, p. 16).

We described in Chapter 1 how our rapidly changing and complex society is having an impact on the way in which people comport themselves today. This also applies to professionals. They present themselves differently to the labour market. Care and support organisations must increase our insight into what motivates professionals and keeps them committed. In these times, many intangible rewards (status, authority ...) have lost importance. Appreciation is mainly expressed in economic terms. Care and support professionals who wish to do their work from the fundamental attitude described above, all too often remain unsatisfied. They often arrive in structures that make it difficult to provide this comprehensive care and support. Their commitment is not always 'appreciated'.

Therefore, it is essential to pay attention to obstacles in the labour market, in organisations and in regulations that inhibit the provision of comprehensive care and support. We will go into this in detail in Part II (How do we get there?).

At a time when the cry of the citizen - and the person with care needs in particular - for self-determination is great, professionals should also be given the space to set their own limits. But a balance is needed. A good, equal care and support relationship can exist only when both parties feel heard and appreciated. It takes two to tango.

2.5. The super professional? Or does the future lie in working together?

If we take all the expectations described in Chapter 2 together, the impression emerges that the person who combines all of this flawlessly must be a 'super professional'. Possessor of an arsenal of values, norms and generalist competencies with which he can place himself above different world views and rise above and even take into account the many petty human characteristics.

We recognise that this is a difficult debate. What kind of professional do we expect? Is it indeed someone who is able to rise above different world views? And how then do you teach this? Or do we precisely want different types of health care providers, with different views of the person as background?

Some nuance is therefore required concerning this ideal.

The described fundamental attitude of the professional, committing as much as possible to the quality of life of the person with care needs, attention for what really matters, *this* should absolutely be the basis for any professional wishing to work in care and support. That is who the 'care and support professional' should 'be' as a person.

We also believe that professionals should at least be trained to reflect on their own world view and their own actions, and on how one as a professional should deal with people who have different ideas, different visions of the person, different backgrounds ... This **ability to reflect ethically** is an important skill in our postmodern society, where the frame of reference is not as unequivocal as it used to be.

The future lies in working together

Furthermore, gradations are possible in the described expectations concerning the extent to which these competencies need to be developed. We do not expect everyone to have the same level of advocacy for example. It also depends on the profession one practices and the amount of room for manoeuvre one is given.

However, we postulate that future care and support will consist of **collaboration among care teams. It is expected that the care teams will give form together to the generalist competencies as per described here, as well as to the specialist competencies.** In this exchange and collaboration, a team will arrive at the necessary ethical reflection. We note that the environment in which a professional moves, in which he or she works or is employed, plays a crucial role. The professional or organisational culture must contribute to making ethical reflection possible.

We present 'collaboration' as a last but **essential competency of the care and support professional . Comprehensive care and support can only be provided in networks, partnerships and among the care and support teams.**

In what follows (Part II), we will describe the conditions needed to achieve good collaboration. These can be found in the organisation of work, in education and in governance.

Bibliography

- Baart A. (2001) *Een theorie van de presentie*. Lemma: Boom. p. 918.
- Baart A. & Grypdonck M. (2008) *Verpleegkunde en presentie. Een zoektocht in dialoog naar de betekenis van presentie voor verpleegkundige zorg*. Lemma: Den Haag. pp. 21-26.
- De Maeseneer J., Aertgeerts B., Remmen R., Devroey D. (red.) (9 december 2014) *Together We Change. Eerstelijnsgezondheidszorg: nu meer dan ooit!* Brussel.
- De Maesschalk S., *Diversiteit in de hulpverleningsrelatie: een benadering vanuit verschillende perspectieven*. In: Willens S.& Mertens J. (2013) Professioneel omgaan met diversiteit. Cahier Welzijnsgids. Kluwer: Mechelen, pp. 7-23.
- De Wachter D. (2012) *Borderline times. Het einde van de normaliteit*. LannooCampus: Leuven.
- Dorn T., Heijmans M. e.a. (2007) *Knelpunten en hiaten bij interventies gericht op ondersteuning bij zelfmanagement, overgewicht en mantelzorg. Een quick scan*. NIVEL: Utrecht.
- Expert Panel on effective ways of investing in health (2014) *Definition of a frame of reference in relation to primary care with a special emphasis on financing systems and referral systems*. European Commission. 66 p.
- Flanders' Care (januari 2013) *Zoekconferentie 'Slimmer zorgen voor morgen'*.
- Freidson E. (1972) *The profession of medicine. A study of Sociology of Applied Knowledge*. p. 440.
- Frenk J. e.a. (2010) Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. In: *The Lancet*, Vol 376, december 4, pp.1923-1958.
- Gemeenschappelijk plan voor chronisch zieken. Geïntegreerde zorg voor een betere gezondheid*. Goedgekeurd IMC 19 oktober 2015.
- Goossensen A. & Baart A. Kwaliteit van zorg 2.0: menslievende, presente en zorgzame zorg. In: *Kwaliteit van zorg*, 2001, nr. 6.
- Hendrickx K., *Interculturele competentie: kennis, vaardigheden en attitude*. In: Willens S.& Mertens J. (2013) Professioneel omgaan met diversiteit. Cahier Welzijnsgids. Kluwer: Mechelen, pp. 44-54.
- Hermans, K., De Coster, I., Demaerschalk, E., Michelini, S., Zelderloo, L., Van Audenhove, C. (2009). *Quality approaches for assuring the quality of training and service provision*. CEDEFOP: Thessaloniki.
- Holtzer L. (2015) *De 7 privileges van de Zorg*. Acco: Leuven.
- Kievitgroep. (s.d.). *Van Dokter ik heb ook iets te zeggen naar Minister ik heb ook iets voor te stellen*. Human Resources: Het nieuwe werken.
- Lechner L., Mesters I. & Bolman C. (2010). *Gezondheidspsychologie bij patiënten*. Van Gorcum: Assen. p. 456.

Orem Dorothea (1971) *Verplegen als compensatie van en educatie bij zelfzorgtekorten*.

SAR WGG (4 november 2010) *Reflectienota Eerstelijnszorg*. Brussel.

SAR WGG (24 februari 2011) *Visienota Maatschappelijk Verantwoorde zorg*. Brussel

SAR WGG (7 december 2012) *Visienota Integrale zorg en ondersteuning*. Brussel.

Sermeus W. Vleugels A. e.a. (2009). *Onderzoek naar de toekomst van transmurale zorgpaden binnen Vlaanderen*. Eindrapport november 2009. Centrum voor ziekenhuis- en verplegingswetenschap: K.U.Leuven.

Van Audenhove Ch. (2015) *Medische keuzes. Praktische gids voor overleg tussen zorgverstrekkers en patiënt*. Lannoo Campus: Leuven.

VANDEURZEN Jo, Vlaams minister van Welzijn, Volksgezondheid en Gezin (21 mei 2010) *Werk maken van werk in de zorgsector. Actieplan ter bevordering van de werkgelegenheid*.

van Ewijk H. (2010). *Maatschappelijk werk in een sociaal gevoelige tijd*, Universiteit voor Humanistiek, Utrecht

van Ewijk H. en Kunneman H. (red.) (2015). *Praktijken van normatieve professionalisering*. Uitgeverij SWP/Amsterdam. p. 461.

Van Herck P. (2015) *Transformeren om te overleven in de zorg. Healthcare in het nieuwe tijdperk*. Voka Books. Lannoo Campus: Leuven.

Van Regenmortel T. *Empowerment en vraagsturing in de zorg. Onlosmakelijk verbonden?* In: *Tijdschrift voor Welzijnswerk*, december 2007, 31e jg, nr 288, pp.6-14.

Visser W. (2013) *Verzorgingssociologie. Visies op samenleven en zorg*. Uitgeverij Coutinho: Bussum.

World Health Organisation (2002). *Global Report. Innovative Care for Chronic Conditions. Building blocs for Action*.

World Health Organisation (2008). *Closing the gap in a generation. Health equity through action on the social determinants of health*.

Zorgnet Icuro (juli 2015) *Zorgwijzer Magazine* 53.

Zorginstituut Nederland (2015) *Naar nieuwe zorg en zorgberoepen: de contouren*.