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HEALTH CARE OF THE ELDERLY

WHO ROR

Report on the Technical Group on
Services and Systems of Care for the Elderly

Helsinki

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1. Introduction

This technical group was held upon the recommendation of the Technical Advisory Committee (ICP/ADR 018) which met in 1978.

Seventeen participants of nine countries (see Annex 1) met to discuss the services and systems of care for the elderly from the viewpoint of their own experience.

2. General objectives

The purposes of the meeting were:

- to encourage the development of services and systems of care which have been shown to meet most appropriately the needs of old people, their families and communities;
- to enable health and social services to develop in ways which are responsive to changes in society, especially by the use of methods which alleviate or overcome the problems arising from diminished availability of traditional family support.

3. Principal topics

The discussions were concerned particularly with:

- the description of existing systems of care with a view to effective coordination;
- determination of a basis upon which services are to be compared;
- identification and description of innovative approaches;
- development of methods for evaluating services.

4. Outcome

Recommendations of the group covered proposals for:

- (a) development of a glossary of working definitions and classifications concerning services for the elderly;
- (b) items to be included in a "questionnaire" on social and health service resources;
- (c) obtaining a systematic inventory of services for the elderly from European countries.

5. Background

The meeting was held in the context of the growth of the older population in most countries of Europe, particularly those over 75 years of age. The elderly, in particular the very old, use increased amounts of health and social services, of which increased use of institutional care is prominent. There is need for better coordination of health and social services in pursuing the broad goals of maximization of the quality of life, the maintenance of the independence of the elderly, and the preservation of social activeness of the elderly. Information is therefore needed as to how existing service systems are being adapted to the changing demographic situation and as to how they are being reoriented to the goal of maintaining the elderly independent.

6. Review on existing services

A literature review by Professor E. Heikkinen on systematic studies of social and health services for the elderly was presented. Existing data sources do not combine health and social services and there is also a need for data on services in Eastern European countries. The review covered three headings: international comparative studies, representative national surveys on social and health services from selected countries, and selected studies on various fields of services for the elderly (including information, work, housing, health services, and other social services). A major section on survey evaluation stressed the need for more objective studies. Researchers used different terms and the conceptual framework was often weak. In particular, an association between medical and social gerontology was often lacking. Most studies to date have been cross-sectional and there is a need for longitudinal and future-oriented studies.

The review concluded with suggestions for the development of research on social and health services for the elderly. There is an immediate need for resources for applied research. At the same time, a strong theoretical basis might reduce conceptual confusion. Increased theoretical deliberation could make it possible to handle the values, aims and principles of policies for the aged. In order to achieve this, methodological questions deserve more attention. There is a need for clear criteria for compiling an inventory. One possible model was presently based on empirical studies carried out at the University of Tampere in Finland, namely services creating promises and possibilities, services which preserve the continuity of life-style, services promoting coping with the activities of daily living, and motivation services.

In the discussion of the review, the need for getting data from other parts of Europe was re-emphasized as was the difficulty presented by the use of different terms. The absence of a theoretical basis and explicit assumptions makes systematic study difficult. The need for practical inventories was expressed, as well as those needed for more scientific studies. It was noted that the development of services was often by enthusiastic and energetic people who had limited interest in and understanding of setting up evaluation mechanisms and it is therefore important to set up data systems for objective evaluation.

The study of the Commission of the European Communities on services for the elderly, which is about to begin, was mentioned and it was pointed out that there would be a full sharing of information between the various studies in order to avoid duplication.

The Tampere model was considered attractive and stimulating but was probably most useful for household surveys, especially at the local level, and it was agreed that the model would be a valuable basis for further scientific research. Finally, though they are expensive, there is no substitute for longitudinal surveys.

7. Existing country services and innovative approaches

Participants described services for the elderly in a number of countries, highlighting innovative approaches. From a background paper on a consultant visit to Denmark, Switzerland and Czechoslovakia, efforts were noted to prevent isolation; to treat the elderly as active members of society; to emphasise home-help, home-nursing and the role of the general practitioner; and to coordinate health and social services, all aimed at keeping the elderly in their own homes as much as possible. The effect of leadership in giving life to programmes was emphasized and other points of special interest were the local level of primary health care network and the use of the public health nurse and doctor team. Conclusions of the consultant were:

- (a) Both developed and developing countries present serious problems as far as the needs of the elderly are concerned.
- (b) Services and systems of care for the elderly differ from one country to another, depending on the existing health and social structure.
- (c) The problem of the health care of the elderly needs a multi-disciplinary approach.
- (d) Every effort should be made to maintain the aged in their homes, and only when this becomes impossible is a move to some type of institutional setting indicated.

- (e) The most important point for success is the coordination and close collaboration with the social services.
- (f) The primary care physician backed up by specialists in geriatric medicine is needed and should be part of an integrated health programme.
- (g) Reorientation of medical curricula is needed to give a high status to professional work in this field and to ensure proper education of doctors and other health workers about the needs of the elderly.

The discussion which followed emphasized the importance of integrating planning and delivery and of encouraging more systematic evaluation of country programmes. Simple and inexpensive methods to study effectiveness were needed and one should find out about inappropriate as well as appropriate use of services.

An interesting example from Portugal of opening institutions for marginal populations to the general public was presented. Liaison among services was difficult to achieve in practice and one should avoid the extreme of advocating forms of care which involve no institutional provision since both institutional and non-institutional care were needed. Data should be separated between the young elderly and the old elderly since their characteristics and needs are different. To aggregate these can lead to obscuring differences and, thus, to planning errors. Although traditions in geriatric services and the stages of development in countries vary, there was a general consensus that the aging process has certain common features everywhere, and, therefore, in principle there should be a number of universal and common aspects which should be sought out. In short, systems and services of care for the elderly are expected to show certain common features.

8. Personnel and institutional resources

Although, in Canada, the percentage of the old was less than in most European countries, it was increasing, most markedly, in the old-old and in older females. There is a relatively high level of institutionalization in Canada because of social, economic, cultural and geographic reasons and because public hospital and medical insurance had been established well before any support from alternative forms of care. Current government policy is to reduce institutionalization and to give greater emphasis to community care, but change was not easy because of long-established traditions, patterns, and incentives. Coordination among responsible government and other departments and agencies is always difficult and fragmentation a problem. A balanced system is hard to achieve.

The education of personnel in gerontology and geriatrics is chiefly through short courses and in-services courses, although formal educational programmes have increased in number and range in recent years. There is still an absence of coordination and many courses are essentially *ad hoc*, heavily applied in focus, task oriented, disciplinary rather than multi-disciplinary, and with little theoretical and conceptual content. The confusion between "medical" and "social" models and the competing self-interest of different professional groups impede development. Training in geriatrics in medical faculties has increased for internists, psychiatrists, family doctors, and others, and there are departments of geriatrics in most schools. The jurisdictional issue between internist geriatricians and family physicians exists, as in some other countries. A number of universities have overall coordinating programmes or offices in gerontology. Various programmes for allied professionals are provided by universities, community colleges, professional associations, service agencies and government.

Assessment of the various mixes of service personnel is needed and one had to have clear objectives to designing appropriate education programmes and methodologies. A variety of types of course is necessary to the existing needs. If the objective is integration of services, then training of health professionals and allied health professionals perhaps needs to be integrated also.

In the USSR, differences among the republics in the percentage of the elderly were noted. Care is provided within a complete system of state health services. Training in geriatrics for physicians of different clinical specialties is being carried on throughout the country. At the Kiev Institute of Gerontology of the Academy of Sciences, USSR, there is a special chair of gerontology for training medical and social gerontology. The main trend in further improvement of health care for the elderly is extensive training of specialists in gerontology and geriatrics. Comprehensive health and social centres are being set up. The idea of working out common criteria, both quantitative and qualitative, for evaluation of systems and services is supported. Financial security, housing at low rent, and personal dignity are very important factors in ensuring a happy and independent life for the aged. Old people are frequently used as teachers and instructors, thus using their experience, in plants and factories. They also work in public education of the young and in some professions can do jobs earning a salary in addition to their pension.

The programmes of the Nordic Association of Old People Activities were described. The Association consists of some 20 voluntary organizations in five countries. Information and experience is exchanged and regular conferences and workshops are held. Attention was drawn to the report on a questionnaire survey of 6000 Swedes over 65 recently published by the Swedish Red Cross and the Gerontological Centre in Lund. Publications of the Institute of Gerontology in Norway were also noted.

Under Italy's current three-year plan there is emphasis on the care of the elderly and money is being given to the regions for this purpose. WHO's advice would be helpful in developing coordinated ways for spending the money. There are needs for methodological tools for assessment of disability, simple devices to measure patient satisfaction, and staff satisfaction, better ways for assessing quality of care, and to set up standards and enforce them.

In Portugal, the percentage of aged ranges from 7 to 15 per cent depending upon the region. The Lisbon area has the most developed services. Hospital statistics and a recent one-day survey showed an increase in the proportion of the elderly in hospitals. It is hoped to carry out this survey more widely.

In Spain, Health Reform is giving special attention to the National Plan of Gericulture and Geriatrics emphasizing integration of all institutions and services for the elderly and keeping the elderly at home where possible. A wide range of in-hospital and out-of-hospital services are being developed.

9. Current Research

Trends in Care of the Elderly in Europe was then discussed. Differences between industrialized and less industrialized countries in Europe were noted. The proportions of the old-old and of elderly women were increasing and the latter are often those with other forms of deprivation. The highest concentrations of elderly are in large cities and in small towns and villages in agricultural and semi-industrial communities. Services tend to be concentrated in the cities and to be underdeveloped elsewhere. The trend towards combination of extramural and intramural services was noted. Any improvement in one must go along with an improvement in the other. There were problems of definitions and on common approaches to measuring need. Working definitions were hard to find. Although efforts were made to develop a model for investigating services, no all-inclusive one had been found. In the area of needs and needs satisfaction, agreement had been reached only on the fact that these are topics which need to be researched.

Developing trends in care systems were: the increased priority for domestically-oriented care over institutional care; the need for a balanced and flexible system focussed on the needs of each elderly person; the family as a key element. Much of what is now being done for the elderly could also be done with the elderly as an active element.

There are deficiencies in techniques and methods of cross-national research as well as in theoretical approaches, the understanding of the aging process as a social phenomenon and in the analysis of personal needs and group demand. An international research office for the dissemination of socio-gerontological information would be valuable.

It was agreed that better methodologies for cross-country comparisons were needed. WHO tended to favour an out-of-house approach with the Organization acting as a facilitator for a network of collaborative institutions. The need for common terms and indicators was stressed. Much conceptual work has been done in earlier studies of international comparison and many methodological issues have been solved. Often researchers were unaware of this. The level of comparability required and the type of methodology used should be matched.

Preliminary information on the WHO cross-country epidemiological study on health care for the aged was presented. The aims of the study were to produce comparable data on various aspects of the life and health of elderly people and their use of health services and to provide base-line data for comparison with future cohorts. The study collected information on the implications for health services of predicted demographic changes. Thus, the results would be useful for planning services and for generating hypotheses about levels of health, the process of aging, and the need for services in different countries. These may form a basis for future intervention studies aimed at the prevention of premature disability.

The methodology was described with special reference to the sample size, age structure, etc. and to the importance of urban and rural differences. A household survey was employed, using interviewers trained in a standardized way. Proxy interviews were allowed but had been uncommon. The data gathered emphasized the background of those interviewed, their health, functional capabilities, the use of and need for health and social services, the way of life, the standard of living, and other problems specific to each country. The final analysis of 11 of the participating countries will be available later in 1980. The study would be of interest to policy makers in many countries. The importance of contacting both governments and research institutes was emphasized for future service studies since they collect different types of data.

The needs of the elderly in Finland based on the results of a national population survey were presented. These had been assessed as part of a larger study undertaken by the Finnish National Health and Social Security Survey for the purpose of describing:

- (a) the basic health status from the viewpoint of chronic illnesses;
- (b) the ability to move and the need for assistance from another person in activities of daily living (ADL) from the viewpoint of the functional status; and
- (c) the prevalence of selected complaints due to health problems.

The survey covered a representative sample of the total non-institutionalized population of the country. Elderly people were represented proportionately in the sample.

Every four out of five persons in the non-institutionalized, retired population had at least one chronic disease or other permanent problem in their basic health status. The retired population is a special risk group with respect to the need for health and social services, since it is well-known that especially the chronic diseases or other permanent problems of health are a major factor in creating a need for these services. Restrictions in the ability to move seem to characterize the retired population. Already a slightly restricted ability to move may hamper many activities of daily living, and this kind of slight restriction was prevalent in all ages among the retired population. The more severe restrictions were especially characteristic of higher ages among the retired population living outside institutional care. Health problems played the decisive role in causing the need of assistance with activities of daily living from another person.

The need of assistance was greater the more strenuous the activity was. House cleaning, shopping, and cooking were activities especially requiring assistance. Assistance for washing, dressing, visits to the W.C. or eating were low since these needs usually lead to institutionalization. Among perceived complaints asked about, fatigue and tiredness was the most prevalent complaint in all age categories and the only one which clearly increased with age. Sleeplessness increased by age in the working population but among the retired population its prevalence remained the same irrespective of age. Melancholy or depression, nervousness or tension, and overstrain showed highest prevalences immediately before or after retirement.

A table illustrating a cumulative index for those needing assistance was shown. The exclusion of institutionalized persons perhaps masked the extent of medical need in the total population of the elderly. Results from a recent Tampere study were also presented.

10. Operationalization and evaluation

A film, "Dementia", obtainable from Miss Dorothy Webster, Scottish Health Education Unit, Health Education Centre, 21 Lansdowne Crescent, Edinburgh, EH12 5EH, Scotland, was shown. It showed community care and illustrated the network of services necessary to make this possible. The link between psychogeriatrics and geriatric medicine in Britain was outlined.

In a discussion on "Making Services Work", the general negative approach to the aged and to the provision of services for them was noted. In a time of static or dwindling resources, the elderly tend to lose out. Even in areas where an adequate range, quantity and quality of facilities is available, the performance of services varies widely. The speaker agreed that this is due chiefly to differences in "style", a composite of the characteristics of services, over and above categories of facilities and personnel, that determine whether or not they work. Those responsible for planning and running services have at least three "constituencies" to satisfy - the users (the patients and their families), the staff who work in these services, and colleagues within one's own and associated professions for whom an effective service for the elderly can make a dramatic contribution to their capacity to function well within their own field. Since the needs of these three "constituencies" may not follow similar directions, a successful service depends on satisfying all three by striking a happy balance. Principles aimed at building confidence in the community, including service workers include: (a) flexibility in finding new ways of doing things; (b) responsiveness and availability to users, including willingness to accept the degree of urgency as perceived by those calling for help; (c) the unhierarchical use of all staff in ways which will give maximum confidence and bring them closer to clients; (d) domiciliary assessment as a cardinal principle, particularly in psychogeriatric services - wherever possible the first contact should be made in the home where functioning capacity in the normal setting may be assessed; (e) a patient's assessed need should determine the services received - this depends on collaboration among services and agencies and often will mean the establishment of joint facilities and services.

Finally, every act of service and intervention must be judged on whether it has been supportive to those who called for help and on whether education of individuals, the public, and the users of services about the needs of the elderly and the complexities of the care system has occurred.

11. Glossary of terms

A compilation, from various sources, of definitions and working terms was presented as background. Since 1973, there had been a strong request at a number of WHO and other meetings for a glossary dealing with the area of gerontology. Possible topics to be covered included age groups, health (public and clinical), the social field, professions, indicators used in research, and schemes of assessment especially with regard to activities of daily living. Some of the questions confronted were: how does one create such a glossary - develop a new one or use existing sources, such as those presented? How extensive should it be and what structure should it take? Who should compile it and how should it be reviewed, accepted and implemented?

A lengthy and detailed discussion followed on the above points. It was finally agreed that if it is useful to compare country experience and services systematically then we need to agree on working definitions. Many working groups have noted the need of such a glossary. Mr William Kerrigan, General Secretary of the International Federation on Aging, is preparing a glossary. A working subgroup prepared a letter to Mr Kerrigan outlining the suggestions of the present Technical Group and offering to serve as reviewers when the glossary is ready. In particular, it should be derived from existing sources. It ought not to be too ambitious and wholly new but realistic and for working purposes among countries. It would be especially useful in non-English speaking countries.

12. Draft "questionnaire" on services and systems of care for the elderly

A draft "questionnaire" was presented to solicit from the participants the types of data they wished to collect. It was envisaged that the final document would be totally redrafted in consultation with relevant experts once the precise data wanted has been clarified. First, a decision was required on the "dimensions" or topics of interest to be included, defining these in detail; second, the indicators, methodology, and techniques required for obtaining the information had to be specified. The importance of being holistic in approach, remembering the family, being aware of the interrelationships in the system, and keeping in mind the historical development of the services was stressed. Services used by the elderly and services provided specifically for the elderly should be distinguished. Data would have to come primarily from publicly available sources. It was decided that the name of "Catalogue of health and social services for the elderly" was preferable and a conceptual model of health services systems of the Finnish Academy was presented for further background. Two subgroups worked on the topics and the broader conceptual model respectively. A range of topics was presented and it was agreed that these should be developed by the WHO staff with relevant consultants.

For purposes of this catalogue a simple model would be used based on the Tampere model, namely:

- (a) services subserving basic vital needs, e.g. housing, money;
- (b) life enhancing services (opportunity creating services) e.g. clubs, transport;
- (c) compensating services;
- (d) care services when function is lost.

This model was seen as a valuable conceptual model for further development for more scientific research studies.

A catalogue for immediate practical use might include the following topics and illustrative items:

I. Demography

Illustrative items are:

- population distribution by 5-year age groups and sex, and special risk groups;
- projections for same age groups 1990, 2000;
- life expectancy at 65 by sex;
- single person households (number of people living alone).

II. Health status

- age-specific morbidity from routine statistics (e.g. hospitalization)
- age-specific condition reported by health interview survey
- age-specific disability collected for International Classification of Impairment, Disablement, and Handicap (World Health Organization, Geneva, 1980).

III. Social status

- census data and social stratification

IV. Economic status

- income distribution classified from national accounts, e.g. minimum pension

V. Norms and indicators

- Illustrative item: health, e.g. institutional beds for the elderly/1000 population.
- Illustrative item: social, e.g. number of social workers/1000 population.

VI. Education and training

- basic and continuing training in gerontology - geriatric medicine specified by categories of personnel;
- does institute of gerontology exist? - address;
- does national gerontological society exist?

VII. Information, innovation and future trend

- Illustrative items: indicators of quality of life in old-age being developed.
- Is information on health care of the aged available in an accessible data bank?
- Give a short description of innovative programmes which may be of interest to countries.

VIII. Legal basis; organizational terms

IX. Resources (input, output)

13. Conclusions

The main topics of the background papers presented as well as the discussion on them can be described under three headings which might serve as points for considering systematic comparison of services for the elderly.

13.1 Heterogeneity

The situation of international documentation and investigation of services shows a very heterogenous field of development. There are deficiencies and gaps in the methodology of cross-national research and in the development of theories on aging. These deficiencies have to be rectified before systematic study can begin. It seems that for systematic and descriptive purposes an approach of systems analysis might suffice very well.

There are big differences between countries. A strong tendency is manifest in Nordic countries and in the United Kingdom, for instance, for coordination and cooperation between health and social services. It might be a working hypothesis that the more developed and the more differentiated the service systems are, the more difficult it will be to discern between health and social service facilities.

International comparative studies of services for the elderly need careful design. Developing trends in care systems are important issues for social policy. These trends need to be analyzed in connexion with the changing need and demand situation of the population and the outcome of the service systems processes (rehabilitation, demands for intensified training of personnel, etc.).

13.2 Need for comprehensive approaches

Since organizational patterns, education and training of personnel and need profiles of the elderly are inter-connected, analysis of services for the elderly necessarily has to adopt a holistic approach to avoid unbalanced consideration of certain aspects. Thus, analyses of service systems can hardly start with only descriptions of so-called facts. Theoretical concepts are necessary.

13.3 Basic patterns and consistency of trends

However heterogenous the international picture may be, research results seem to show a relative consistency in certain patterns. Examples of such patterns are:

- very clear differences in types of service need and profiles of deficiencies between different age groups, demanding distinction between the "young-old" and the "old-old";
- comparison of services without a historical perspective (e.g. time-series material) leads easily to misinterpretation;
- research results presented after a study in Finland proves again that explanation of the living conditions and situation of the elderly demands an analysis of inter-relationships rather than of single factors;
- comparison of service systems for the aged on an international level show conflicting experiences due to different historical-social evolutions;
- empirical evidence as well as sociological conceptions show that analyses of service systems have to take into consideration the role of the family, however fragmented it appears to be.

14. Recommendations

1. The topics and structure of the Inventory or Catalogue of health and social services and systems are to be developed as agreed above by the WHO staff in consultation with relevant experts.
2. The glossary of definitions being prepared by Mr Kerrigan, as per the general guidance of the letter drafted by the Technical Group, would be reviewed by the members when it is ready.
3. A systematic inventory will be proceeded with only in the light of the experience from the WHO Epidemiological Study and, in the first instance, only in the countries which participated in that study.

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