Workshop "Care Provision in Ageing Societies: What are the Policy Challenges and How to Address Them"
(Malta, 19 - 21 May 2005)

REPORT

A. INTRODUCTION

1. A workshop entitled "Care Provision in Ageing Societies: What are the Policy Challenges and How to Address Them" was held in Malta from 19 to 21 May 2005, within the framework of the follow-up to the UNECE Ministerial Conference on Ageing (Berlin 2002). It was co-organized by the United Nations Economic Commission for Europe (UNECE) and the International Institute on Ageing, UN-Malta (INIA), in cooperation with the European Centre for Social Welfare Policy and Research (ECV), and the Institute for Older Persons and Social Services (IMSERSO) of the Spanish Ministry of Labour and Social Affairs. The workshop was attended by 26 experts from various academic institutions, government agencies and NGOs from 15 UNECE member states, as well as from international organizations active in the ageing field. The list of participants is attached to this report as Annex A.

2. The objective of the workshop was to promote the national and regional implementation of the commitments related to care provision contained in the *Regional Implementation Strategy* (RIS) for the *Madrid International Plan of Action on Ageing 2002* (MIPAA). The attending experts provided independent advice on: /a/ the issues related to care-provision covered in the Regional Implementation Strategy, which are deemed to be of particular policy importance and need be addressed as a matter of priority; /b/ the difficulties encountered so far in meeting the commitments and policy objectives laid out by the *Regional Implementation Strategy*, and good practices in the field; /c/ the appropriate social indicators that could help national governments assess how their national and local policies meet existing and future needs and requirements, and guide policy makers and other stakeholders in their work towards fulfilling the commitments made with the Regional Implementation Strategy; /d/ the appropriate policy measures to address the challenges related to care-provision.

3. The deliberations at the workshop were organized as a series of plenary and working group sessions. The agenda is attached as Annex B.

B. FUNDAMENTAL CONSIDERATIONS

4. The experts emphasized that a change of paradigm in the general approach to long-term care and in related policies is indispensable, and is in the strong interest of all concerned parties. At the core of this changed paradigm should be the understanding that preventive measures need to be strengthened and diversified wherever possible. This applies to a multitude of different aspects of individual and collective life, as well as to the whole life-course of the individual. Appropriate preventive measures not only have the capacity to significantly retard the need of long term care and can save substantial financial resources, but they also will improve the quality of life of individuals, their families and partners, as well as of the communities they live in.

5. Adequate and acceptable care policies need to be embedded in the common value system of a given society. They must be based on the concept of fundamental rights and aim at the shared objectives of the society. The participants in the workshop recalled that the *Berlin Ministerial Declaration* emphasized that the "promotion and protection of human rights and fundamental freedoms are essential for the active participation of older persons in all aspects in life and for the creation of a society for all ages". The need to care for the frail, disabled and older persons in our society is based on the recognition and respect of such fundamental societal values as human dignity, equality, justice, solidarity, social inclusion, participation and non-discrimination as well as on the implementation of the corresponding human rights. Consequently, the provision of care constitutes a commitment of society towards the individual. It lies in the general interest of this very society and represents a common good for which the State carries a particular responsibility.

6. This basic understanding should guide the public discourse and direct policy makers in their attempt to conceive and shape adequate responses to the growing need of care provision in the ageing societies of the UNECE region. On these grounds, all stakeholders need to agree on, *inter alia*, effective care assessment, the forms of care provision, efficient infrastructures and division of tasks between various actors, quality standards, financing systems, training, protection of users and providers, the role of existing social security provisions in providing long-term care and the need for new social security arrangements, as well as monitoring and evaluation of all participants.

7. The experts also highlighted the importance of prevention, and the concept of active ageing. They emphasized that the possibilities and the opportunities of active ageing are largely determined by the choice of lifestyle, the availability and use of preventive measures, as well as the active maintenance of functional capacities at any phase of individual lifetime. This is a shared responsibility of societal actors, and the individual. The state should determine appropriate policies, pass adequate legislation, provide meaningful incentives and, in general, create the necessary environment for local authorities, health and rehabilitation institutions, market providers and other organizations of civil society to offer comprehensive services in the area of prevention and counselling. Public campaigns and the media should encourage the choice of healthy lifestyle at all ages. They should also point out that it is never too late to change lifestyle and benefit from it. Functional capacities, which have to be developed, maintained, or retrained, are to be understood, in this context, as having physical,

intellectual, psychological, as well as emotional and social dimensions. Volunteering has to be acknowledged as an important part of active ageing, and an important feature of self-realisation and recognition of the person. as well as an enrichment of the community. It should also be recognized as a valuable contribution to the cohesion of society.

8. The experts emphasized that there are important gaps in our knowledge of the issues related to care, which need to be addressed through concerted research and data-collection efforts. Specifically, it was pointed out that we are dealing with individual men and women in different stages of ageing, who experience "dependency careers" of self and of others. These careers need to be examined, both in the interplay of formal and informal care, and across time by longitudinal studies following the individual. The shape and duration of dependency and caring careers must be considered in relation to age, gender, marital status and socio-economic background. In this context, it was emphasized that in Europe there are very few longitudinal studies on care-giving, and almost none that would allow broad cross-national comparisons. In view of the importance of the issues involved, such studies were identified as indispensable for effective policy formulation.

C. MAIN ISSUES RELATED TO CARE PROVISION

9. The experts identified the following issues as being of primary importance and requiring urgent policy action:

2.1. Prevention of dependency in old age and help for older persons to maintain their autonomy and independent living, within the context of policies promoting active ageing

10. This issue refers to Commitments 7 and 9 of the *Regional Implementation Strategy*. The main difficulties encountered in addressing it, stem from the insufficient importance given to the policies promoting active ageing, and to the prevention of disability in older persons.

11. Among the good practices cited by experts were the trauma prevention programmes adopted by some countries, and the emphasis on rehabilitation after acute events (e.g. stroke, falls). Specific examples include the rehabilitation work carried out in Malta[1], the awareness raising campaign concerning fall prevention among senior citizens in Austria[2], as well as the "intermediate" care services (with an emphasis on rehabilitation after discharge from hospitals) that are being developed in England[3]. As far as the prevention of disability is concerned, good practices worth considering include the

[1] Most of that work is being carried out at the Zammit-Clapp Hospital.
[2] That campaign was funded by the Austrian Ministry for Social Security, Generations and Consumer Protection.
[3] Further information and "good practice examples" on intermediate care in England are available from the website of the Department of Health:
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeoplePromotionProject/OlderPeoplePromotionProjectArticle/fs/en?CONTENT_ID=4002287&chk=4xCeO8

"preventive home visits" in Denmark[4], and the so called "active health promotion in old age" -- a new preventive intervention programme developed in Germany[5].

12. The experts recommended that two groups of indicators (instrumental and outcome) be considered in conjunction with each issue. With respect to the prevention of dependency and the maintenance of autonomy and independent living, these two groups of indicators include:
Instrumental: Public expenditure on preventive measures, in comparison with curative measures.
Outcome: /a/ prevalence of trauma; /b/ number of assistive devices used. /c/ increase in the health expectancies indicators (Healthy Life Expectancy, or Disability-Free Life Expectancy)[6].

13. The following policy measures were recommended to better address this issue: /a/ support for the development and production of assistive devices; /b/ promotion of technological innovations. The experts emphasized that these measures have to be part of broader active ageing programmes, promoting physical and intellectual activities.

2.2. Provide for a continuum of care across health, long-term care and other social services

14. This issue refers to Commitment 7 of the RIS. The difficulties experienced so far in addressing this issue stem mainly from the lack of coordination between health and social care systems and are related to differences in responsibilities, funding mechanisms, rights and entitlements of these systems. The lack of coordination is particularly visible at the interfaces between primary and secondary care, between hospitals, institutional and community care, as well as other relevant services. Persons in need of long-term care, as well as their families often experience a lack of information, unequal access to services and the uncoordinated transfer of responsibilities from one agency to another. This is particularly problematic for persons with complex needs and results also in ineffective allocation of resources when these persons repeatedly end up in hospitals or in other institutions that are not designed to adequately cater for them.

15. Among the good practices cited by the experts were: /a/ the emphasis that some countries place on the interdisciplinary training and teams in hospitals and nursing homes; /b/ the "one-shop" approach adopted in some countries, with the creation of information/coordination centres; and /c/ the programmes, where social workers look after patients when they leave hospital, and provide training for family carers.

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[4] For more information see: Hendriksen C. and M. Vass. 2003. Preventive home visits to elderly in Denmark. *Generations Review* 13 (3): 14-7, and Vass, M. et al. 2002. Preventive home visits to older people in Denmark: Methodology of a randomized controlled study. *Aging Clin. Exp. Res.* 14: 509-515

[5] For more information see: Dapp, U. et al. 2005. Active health promotion in old age: methodology of a preventive intervention programme provided by an interdisciplinary health advisory team for indepenent older people. *J. Public Health* 13 (3): 122-127

[6] See the work on this by the REVES and Euro-REVES networks (http://euroreves.ined.fr/), as well as by the World Health Organization (http://www.who.int/health-systems-performance/).

16. Some countries have tried to overcome the structural division of social and health care systems by establishing 'care trusts' (UK), or by merging policy responsibilities into one ministry (Denmark and Malta[7]). Coordinated or even integrated models have been set up in many European countries during the past 20 years, using instruments such as multi-dimensional needs assessment, case and care management, joint training and working of health and social care staff, local coordination and information centres etc. (see, for instance, descriptions and analyses of almost 50 model projects in nine EU-countries and also, for management tools in integrated care[8]). Still, mainstreaming of such models has not been achieved in any country.

17. The indicators considered by the experts included:
Instrumental: the existence of coordination mechanisms between the health and social care systems at different levels, in particular at the financing level and at the level of service delivery.
Outcome: /a/ number of hospital (re-)admissions of older persons in need of care per year; /b/ length of stay of older persons in hospitals; statistics on community care services (hours, types of service, staff).

18. The policy measures needed to address this issue include, *inter alia*, the development of mechanisms to overcome the division between health and social care systems and informal care. Coordination is also needed between central legislation, decision-making, and the decentralized delivery of services. Results of research suggest that it is of particular use to organize hospital discharges of persons with long-term care needs with the help of intermediate care models or a case manager to prepare the social and housing environment (family, technical aides, adaptations, services).

19. The knowledge gaps and research priorities related to this issue are mainly linked to the need to develop new organisational structures and professional profiles of case/care managers/management, and to study the (cost)effectiveness of coordination and integration.

2.3. Ensure appropriate organization and financing of long-term care provision, based on comprehensive need assessment

20. This issue refers to Commitment 7 of RIS. A number of current difficulties/inadequacies of care systems were identified, including: /a/ insufficient coordination of various forms of services; /b/ poor planning, including lack of explicit goal setting and inadequate monitoring structure; /c/ lack of sustainable financing; /d/ inadequate care allowances and income support payments; /e/ lack of consumer choice.

21. Good practices highlighted by the experts include the universal long-term care programmes in the Nordic countries; the long-term care social insurance in Germany, as well as the long-term care allowances in other countries (e.g. Austria); and programmes of consumer directed services that should not be too limited to specific target groups. It

[7] In 1987 the post of a parliamentary secretary for the elderly (as a member of the Cabinet) was established in Malta.
[8] For more information on the model projects see http://www.euro.centre.org/procare; the management tools are described in: http://www.ehma.org/carmen/index.html

should be recognized that social security schemes, in particular in the form of a long-term care insurance, can play an important role as a means to finance long-term care.

22. The following instrumental indicators were recommended: /a/ Coverage of long-term care services (public, private, or voluntary); and /b/ Sources of financing of long-term care services (public, private, or voluntary).

23. The policy measures needed to address this issue include, *inter alia*: /a/ coordination of services; /b/ allowing wider choice of services for consumers; /c/ integrating long-term care services; /d/ further recognition and facilitation of the work of non-governmental organizations in care provision; /e/ developing specific financing structure.

2.4. Ensure quality of care services

24. Quality development and assurance are issues related to commitments 7 and 9 of RIS. Difficulties encountered are most often the lack of defined quality standards in long-term care services and in institutions. Also, existing measures and control mechanisms are often not adequate and not efficient to guarantee quality in personal services, though future users will be much more demanding than the current generation of older persons in need of social and health care services and institutions. Quality of care is directly impacted by levels of staffing, as well as by staff qualifications and training. Adequate public spending and more investment are needed to ensure quality of care in long-term care systems.

25. First important steps in defining sustainable objectives and standards that comply with the existing "care culture" and economic capabilities could be derived from legal regulations in Austria ("Residential Care Act"[9]) and Germany (Quality assurance in the framework of the LTC Insurance), as well as the individual treatment plans in public care in Norway. Furthermore, recent developments concerning the accreditation of public and private health and social care services and institutions in Italian regions and in France should be considered. Finally, a EU-Leonardo project, which is currently developing a quality management system for use in institutional care, will be a useful source of information support towards a dynamic quality improvement in this sector[10].

26. The instrumental indicators considered by the experts included: /a/ the existence of a social and political process to define and assure sustainable quality standards for respective regions or countries (valid for all kinds of providers); /b/ defined standards for social and health care workers' education and continuing training; /c/ number of personnel involved in the process of total quality management.

27. The following policy measures were recommended: /a/ define through a participatory approach standards to guarantee service quality, including standard structure of care (settings; policies and guidelines; personnel available, its qualification and training), the care process (activities and experiences of delivering and receiving

[9] It regulates the minimum standards applicable to nursing homes and other institutions providing long-term care. In conjunction with that an ombudsman institution was established to oversee this arrangement. Similar instruments exist also in the Netherlands and Sweden

[10] For more information see: http://www.e-qalin.org.

care), and the outcomes of care (the impact that the use of services has on care receivers); /b/ monitoring of care in the public and private sectors; and /c/ establishing regulations concerning quality assurance.

28. Quality improvement of existing services and institutions must be at the heart of future strategies in the area of long-term care. This can be achieved only by involving all relevant stakeholders in the definition of standards to be achieved in the respective political, economic and cultural context. A general quality management approach that goes beyond the definition of minimum standards and emphasizes a continuous quality improvement needs to be adopted. Such an approach could be based on the definition of structural, procedural and result oriented quality standards. Thus, rather than defining conclusive quality standards for the UNECE region, each country would be free to define sustainable objectives and standards that comply with the existing "care culture", welfare state traditions and economic capabilities.

2.5. Recognition and protection of informal carers, including the role of older persons as care-givers (from an economic, social, psychological, and health point of view)

29. This is an issue related to commitments 2, 8 and 9 of RIS. The experts were of the opinion that as informal carers (family members, friends, neighbours) are at risk of severe burnout, exhaustion and injuries, programs and policies need to consider them as an important target group for intervention. The main difficulties encountered by policy makers and practitioners in addressing this issue include: /a/ lack of comparable data and research; /b/ the lack of appropriate support for ageing and increasingly frail informal carers; /c/ the limited access to information about the availability of support services for carers.

30. Among the good practices discussed during the workshop were the efforts to make day care centres widely available, and other arrangements offering respite to family carers (short-term care) that nowadays can be found in many countries but often only in larger cities. Such facilities have to be complemented by independent information, counselling and training centres for carers as, for instance, in the Netherlands, Germany, Austria and Malta[11]. One specific example that was discussed was Sweden, where the development and implementation of a national 3-year Action Plan (1999-2001) stimulated local authorities to develop an infrastructure of services targeting family caregivers (e.g. by setting up caregiver resource centres offering training, counselling, support groups, respite care, information and resources for family caregivers, including day care programs for their disabled family members). Another example was Germany, where the Federation of Advice Centres for Older People and Family Carers (BAGA) has published a manual for professionals on how to give advice and support to family carers of older people suffering from dementia, including practical training, support groups for older people suffering from dementia, advice and counselling in domestic care environment, etc.[12]

[11] In Malta, in-service training programmes are regularly organized both for formal and informal carers. The European Centre of Gerontology, University of Malta provides shorts courses and university degree programmes.

[12] More information on national practices is available on the www site of the EU funded project EUROFAMCARE: http:// www.uke.uni-hamburg.de/eurofamcare

31. The following indicators were recommended:
Instrumental: /a/ Availability of advisory services, training and capacity building programmes for carers (both in the provision of care to others, and in meeting their own needs); /b/ Number and type of programmes/organisations targeted on older persons, providing care for others; /c/ Number and type of programmes/organisations for carers; /d/ Number of users of day-care, respite and other care services; /e/ Number, age and sex of informal carers, according to care-giving status; /f/ existence of a "National Carer's Organisation" that is publicly recognized as representing body of family and informal carers.
Outcome: /a/ number of carers in relation to population in relevant age groups, by carer status (social relation; employment, gender and age-groups); /b/ health situation of carers; /c/ average length of caring in the community; /d/ level of "burn out", morbidity and mortality of care-givers; /e/ level of satisfaction or well-being of care-givers.
Given the importance of these indicators, experts agreed to continue working on a more complete list. A small group was formed to lead this work.

32. The policy measures needed to address this issue include, *inter alia*: /a/ creation of an infrastructure to train and provide advice to care-givers; /b/ provision of better access to and quality of information about existing services; /c/ facilitating periodical respite care services for care-givers; /d/ provision of regular medical and psychological assessments for care-givers; /e/ ensuring the collection of adequate information on carers, including the creation of a register of care providers by age, sex, and marital and employment status.

33. Research and data collection efforts should focus on the economic, social, psychological and health impact of care (both given and received). It was emphasized that research should encompass both micro- and macro-level approaches, focusing on 3 levels: the individual, the family and the society.

2.6. Reconciliation of work and family responsibilities

34. This is an issue related to commitments 2, 4, 5, 8 and 9 of RIS. The main difficulty encountered by policy makers and practitioners in addressing this issue includes the lack of working-time flexibility and social protection measures for care-givers in the labour force.

35. The good practices identified by the experts included: /a/ provision of social security, including pension credits for care-givers; /b/ paid leave to care for family members, in particular in terminal cases; /c/ measures of real labour-market integration and social protection for care-givers; /c/ wide availability of day care services that provide care during normal working hours. The specific examples that were discussed include Austria, where preferential insurance terms and pension contributions are given to non-employed family carers in the form of free non-contributory co-insurance with sickness benefits for those receiving the long term care allowance for the more dependent (levels 4-7) with the state paying the employer's contributions. Denmark also has useful experience in considering care-giving for children, dependent adults and dependent older people as a continuum in care throughout the lifespan, with some common policy issues and solutions. Cited also was the German *Pflegeversicherung*

system, and the provisions in Italy, where working carers could take 3 days off per month of paid leave to provide care to a close family member[13].

36. Two instrumental indicators were suggested to monitor progress: /a/ existence and type of pension credits and other social protection measures; /b/ existence and type of programmes allowing flexible working arrangements and the provision of leave from work for family carer (care leave, care breaks, care allowance, care pension credits, care time off). Outcome indicators could include: /a/ labour force participation of carers of working age; /b/ monitoring of social protection coverage of carers.

37. Encouraging employers to provide more flexible working arrangements and career breaks for care-giving, and ensuring the provision of adequate social security coverage for family carers (pension contribution, health care coverage, injury and liability, etc.); designing long term care services that allow carers to combine work and caring were cited as policy measures needed to address this issue. To promote measures to ensure equal sharing of family care responsibilities between men and women. Provide high quality facilities for older persons living with their families.

38. Some of the research issues and knowledge gaps related to the reconciliation of work and family responsibilities include: /a/ the distribution of responsibilities (in terms of work and income, care of dependent family members, and social protection) between men and women, and across generations, needs to be better studied and documented; /b/ an inventory of existing family-friendly policies and services, which support working family members in coping with their caring roles, needs to be created.

2.7. Foreign-born providers and recipients of care

39. This issue relates to Commitment 5 of RIS. Older immigrants and/or ethnic minorities in need of long-term care often remain without adequate care due to little awareness about existing services that, on their turn, are not sensitive enough to the cultural background of clients. At the same time, most European countries and the US are witnessing the influx of an increasing number of health and social care workers from third countries. More and more countries are forced to resolve labour shortages in the health and long-term care sectors by recruiting and training workers from abroad, thus creating integration problems in the receiving countries. Migrant workers have become an increasingly important resource of informal care, replacing/complementing family care, in particular in countries where adequate services are missing. Many migrant carers are deprived of working permits and do not have access to social security, which puts them in precarious situation. Older persons cared for by these carers suffer from the discontinuity of 'personnel', as migrant carers often have to leave for visa or other reasons. Another issue that was highlighted, relates to the cultural and communication problems experienced both by providers and the recipients of care.

40. Experts emphasized that the impact on the countries of origin of foreign-born workers needs to be recognized, especially when recruiting qualified staff. As this staff has been trained by the countries of origin, the "brain drain" often results in great loss to these countries.

[13] Law No. 104 of 1992

41. The source of good practice examples addressing culturally sensitive care is the Minority Elderly Care (MEC) Project[14], a research project supported by the European Commission within the 5th Framework Programme, which covers the United Kingdom, France, Germany, Netherlands, Spain, Finland, Hungary, Bosnia-Herzegovina, Croatia and Switzerland.

42. The indicators suggested to monitor progress on this issue include:
Instrumental: /a/ Availability of culturally sensitive care (including the right to translation of information); /b/ Availability of specific training programmes for foreign and ethnic minority care-givers;
Outcome: Number of certified foreign-born care-givers.

43. The following policy measures were deemed necessary in order to better address this issue: /a/ specially designed information and training programmes; /b/ the implementation of decent work practice for foreign-born care-givers; /c/ special counselling possibilities.

44. The main research issues related to foreign-born providers and recipients of care include: /a/ the specific needs of migrant professional carers; /b/ the impact of migration of professional carers for the countries of origin; /c/ the assessment of real access to and use of social services by ethnic minorities and immigrants; /d/ the quality/satisfaction of the care provided.

2.8. Meeting the need of older persons for adequate mental health services, and addressing the special care needs of patients with dementia and/or depression and their (informal) carers

45. This issue refers to Commitment 7 of RIS. The major difficulties encountered so far in addressing this issue include: /a/ problems in diagnosing mental health conditions; /b/ limited training and understanding of diseases by both health and care professionals and family members; /c/ false perception of the diseases by health and care professionals, family members, and society at large; /d/ limited out-patient care resources.

46. The good practices in the field include /a/ measures taken in several countries in the region to establish and maintain social networks for patients; /b/ the self-help groups and advisory centres for carers; /c/ the measures to sustain and optimise cognitive functions of patients throughout a continuum of care. A specific example that was discussed, were the Alzheimer Societies, which play an important role in many countries of the region -- e.g. in the UK they have 25,000 members and 300 centres running quality day and home care services.

47. The following indicators were suggested:
Instrumental: number and type of programmes to ensure adequate mental health services, and meet the special needs of patients and their carers;

[14] Project leader: Naina Patel, Policy Research Institute on Ageing and Ethnicity (PRIAE), London, UK. For further details see: www.priae.org.

Outcome: /a/ the speed of progression of cognitive impairment; /b/ prevalence and trends of depression in nursing homes; /c/ level of stress of carers, in institutions and at home.

48. The following policy measures were recommended: /a/ in-service training of carers and other staff; /b/ public campaigns to correct false perception and prejudice about mental health in old age; /c/ standardization of protocols for diagnosis and treatment.

49. When discussing the knowledge gaps in this field, experts highlighted the importance of better evaluating the effectiveness of the existing programmes aimed at improving cognitive and emotional functions.

2.9. Environmental and physical factors as reliable predictors to maintain the independent living

50. The experts were of the opinion that this issue is directly related to commitments 7 and 8 of RIS. The main difficulties encountered by policy makers and practitioners in addressing it include: /a/ lack of information on the role of environmental factors as determinants of independent living; /b/ the lack of appropriate instruments to assure the proper environment in and design of homes for older persons with physical and mental limitations[15]; /c/ the absence in many countries of awareness of the importance of environmental factors for the possibility to maintain independency; /d/ the concepts of enabling environments and adequate accessibility in the home is non-existent in many societies.

51. Among the good practices highlighted by the experts were the efforts under way to establish international projects such as ENABLE-AGE[16], and to adapt homes and the physical environment in the communities where older persons live to their functional limitations[17].

52. The following indicators were recommended in order to facilitate monitoring the progress made in dealing with this issue:
Instrumental: /a/ number and type of programmes to create barrier-free environments; /b/ number and type of programmes/organisations providing training to interdisciplinary teams in creating barrier-free environments; /c/ availability of programmes to disseminate good practices;
Outcome: /a/ changes in the burden on formal and informal care systems; /b/ changes in the quality of life; /c/ maintenance of independent living in own homes, and better performance of instrumental tasks by older persons.

[15] Mental limitation calls for a different approach because in most cases it reduces independent living.
[16] This project has been sponsored by the European Commission (for more details see www.enableage.arb.lu.se).
[17] In Hungary the adaptation has been sponsored by the Ministry of Youth, Social and Family Affairs and Equal Opportunities. Information about the work done in this field by the International Council for Caring Communities (ICCC), is available at: http://www.international-iccc.org/.

ANNEX A

Workshop

"Care Provision in Ageing Societies: What are the Policy Challenges and How to Address Them"
Malta, 19-21 May 2005

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ANNEX B

United Nations Economic Commission for Europe
and
International Institute on Ageing (United Nations-Malta)

in cooperation with
European Centre for Social Welfare Policy and Research
and
Institute for Older Persons and Social Services (IMSERSO)
Ministry of Labour and Social Affairs, Spain

Workshop
"Care Provision in Ageing Societies: What are the Policy Challenges and How to Address Them"
(Malta, 19-21 May 2005)

Provisional Annotated Agenda

18 May 2005 (Wednesday)

19:30 Reception hosted by the Hon. Dr. Michael Frendo, Foreign Affairs Minister, Government of Malta, and Professor Frederick F. Fenech, Director of the International Institute on Ageing, United Nations – Malta

(Pick up from the hotel 19.00)

19 May 2005 (Thursday)

9:30- 9:50 *Official Opening*

Speakers: Hon. H. D'Amato, Parliamentary Secretary for the care of the elderly, Ministry of Health, the Elderly, and Community Care, Malta
Mr. A. Chowdhury, Director, Economic Analysis Division, UNECE
Prof. F. Fenech, Director, INIA

9:50-10:30 *Plenary Session 1: The follow up to the Berlin Conference and the objectives of the workshop*

Chair: J. Troisi
Speakers: N. Botev, E. Hönigsperger, A. Sidorenko

The participants will be briefed on the outcomes of the Second World Assembly on Ageing (Madrid, April 2002) and the UNECE Ministerial Conference on Ageing (Berlin, September 2002); the work on the follow-up to the Berlin Conference will be presented. In that context, the aims of the workshop and the task of the group of experts will be outlined.

10:30-11:00 Coffee Break

11:00-13:00 *Plenary Session 2: Monitoring and appraisal mechanisms for RIS, and how to cover the issues related to care within them*

Chair: N. Botev

Speakers: M. Huber, M. Lagergren, A. Comas-Herrera, R. Sigg

The speakers at this session will present different approaches to establishing mechanisms for the monitoring and appraisal of the implementation of the RIS commitments. The presentations will be used as a foundation for the deliberations on the most appropriate indicators on care, and the identification of best practices in the field.

13:00-14:15 Lunch

14:15-16:00 *Working group session*

16:00-16:30 Coffee Break

16:30-18:00 *Working group session (cont.)*

20 May 2005 (Friday)

9:00- 9:30 *Plenary Session 3: Progress reports by the chairs of the working groups*

Chair: E. Hönigsperger
Speakers: F. Fennech, G. Hagestaad, D. Jarre

The chairs of the three working groups will brief the plenary on the progress made during the first day of work, followed by a brief discussion from the floor.

9:30-11:15 *Plenary Session 4: Country experiences and best practices in the field of care provision*

Chair: B. Marin
Speakers: K. Leichsenring, H. Doehner, J. Troisi, Z. Szeman, R. Fernandez-Ballesteros

The session will include a series of presentations on large international projects in the field of care-provision, and on the national experiences in several UNECE countries. These presentations are intended to provide a basis for the identification of issues that are of particular policy priority and of best practices in the field of care-provision.

11:15-11:45 Coffee Break

11:45-13:00 *Plenary Session 4 (cont.)*

13:00-14:15 Lunch

14:15-16:00 *Working group session*

16:00-16:30 Coffee Break

16:30-17:30 *Working group session (cont.)*

21 May 2005 (Saturday)

9:00-10:00 *Distribution of a draft report based on the deliberations during the first 2 days; Time for studying it*

10:00-12:45 *General debate*

Chair: S. Sidorenko

12:45-13:00 *Closing*