



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



## **26<sup>th</sup> PAN AMERICAN SANITARY CONFERENCE**

### **54<sup>th</sup> SESSION OF THE REGIONAL COMMITTEE**

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### **HEALTH AND AGING**

Population aging in the Region has three essential features: all nations in the Hemisphere are experiencing it; the rapid growth of aging populations deeply challenges the capacity and willingness of the social and health sectors to provide coordinated systems of care; and extended life expectancy free of disability for older persons is possible only if governments provide adequate support.

The United Nations has adopted an International Plan of Action on Aging, 2002, at the Second World Assembly on Aging in Madrid in April 2002. The Plan responds to opportunities and challenges of individual and population aging. The implementation of the Plan of Action is the responsibility of Governments with the support of international and regional collaboration and civil society. The present document provides Member States with an analysis of priorities to advance health and well-being into old age. It also provides a road map to the implementation of necessary actions to ensure equity in health for older persons in the framework of the Madrid International Plan.

The 130<sup>th</sup> Session of the Executive Committee reviewed and expressed its support for regional collaboration for the implementation of the International Plan of Action on Aging and adopted Resolution CE130.R19 for consideration by the Pan American Sanitary Conference. The Conference is invited to further analyze and discuss the document with the aim of enhancing regional and national action in support of the development of aging-appropriate and aging-friendly health and social services to support active aging.

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Annex: Resolution CE130.19

## **Health of Older Persons: Taking the Next Steps**

### **1. Introduction**

The Region's population is aging at an accelerated pace. Declining fertility rates combined with steady improvements in life expectancy over the latter half of the twentieth century have produced dramatic growth in population aging. The number of persons 60 years and older in the Region is currently 91 million. An expected annual rate of growth of 3.5% in this population during the first two decades of the century will bring the total of persons 60 years and older to 194 million. This number will grow to 292 million by the middle of the twenty-first century. Currently, older persons represent 8% of the total population in Latin America and the Caribbean, and 16% in Canada and the United States. By 2025, 14% of the population in Latin America and the Caribbean will be 60 years of age and older. This trend has immense implications for public health because of its potential to overburden existing services and to create an intergenerational competition for scarce resources. However, Member States still have time to act and prepare for this challenge by implementing policies for the reorientation of primary health care targeted to health promotion, disease prevention and management and rehabilitation for older persons. Furthermore, because population aging is occurring at different stages in the Region, there are important opportunities for Member States to learn from each other's experiences. Taking advantage of these opportunities requires information for the development of policies, plans, and programs; models for creating a continuum of coordinated services providing community-based care; and regional coordination to facilitate cross-national planning and evaluation.

In this document, we argue that investing in the health of older persons throughout the Region of the Americas is an investment in development. We further demonstrate that the application of evidence-based public health strategies can promote active aging and reduce significantly the rate of premature disability in older age.

The purpose of the present document is to: (a) review the situation of older persons in the Region; (b) discuss the principle obstacles to the development and implementation of a public health policy on aging in the Region; (c) present the priority areas for the implementation of the Madrid International Plan of Action; and (d) request the Pan American Sanitary Conference to further analyze and discuss the document with the aim of enhancing regional, national, and community action in support of the rights of older persons, and to encourage the development of aging-appropriate and aging-friendly health and social services to support active aging.

## **2. Current Situation of Older Persons in the Americas**

### **2.1 *Health Status and Equity***

In 1998, PAHO coordinated a multicenter Study on Aging, Health, and Well-being (SABE) in seven major cities of Latin America and the Caribbean (Bridgetown, Buenos Aires, Havana, Mexico City, Montevideo, Santiago, and São Paulo). A total of 10,600 statistically selected interviews of persons 60 years of age and older were completed. SABE was made possible with the contributions of a number of funding partners, collaborating centers, and universities throughout the Region.

Health differentials and other inequities in the Region are complex and far-reaching. They stem from such diverse causes as gender differences, discrimination, and socioeconomic status throughout the life course. These differentials translate into different rates of morbidity as well as differentials in well-being and disability. In Canada and the United States, over 76% of persons 65 years and older report having good or excellent health, while in the SABE survey, less than 50% of elders from all cities except Buenos Aires (63%) and Montevideo (61%) report good or excellent health. Uniformly throughout the Region, men report having good health more frequently than women, and those with seven or more years of education report having good health more often than those with fewer than six years of education. For older persons who are poor, the consequences of earlier life experiences are worsened through further exclusion from the priorities of the health system.

### **2.2 *Prevalence of Chronic Diseases Among Older Persons***

Chronic diseases can become a significant health and financial burden to the older person, the family, and the health care system. For many "young-old persons" chronic conditions as diabetes, heart disease, and hypertension are still preventable, and the evidence shows that highly effective interventions exist and can produce significant savings to the health care system and to society in general. In addition, the lack of secondary prevention of these chronic diseases can lead to significant declines in functional capacity and the ability to remain independent as well as significant avoidable costs in health care.

The prevalence of chronic conditions varies in the Region. In the SABE survey, hypertension was reported by one out of every two persons 60 years and older; the lowest percentage was reported in Mexico City (43%) and the highest in Sao Paulo (53%). One out of five persons reported having heart disease, with the exception of elders in Bridgetown (12%) and in Mexico City (10%), where heart disease was reported less frequently. In most cities, at least one out of three older adults reported having arthritis. However, arthritis appeared to be most significant in Montevideo (48%), Buenos Aires

(53%), and Havana (56%), where the proportion was closer to one out of every two elders. Diabetes was highest in Bridgetown and Mexico City, with 22% of older persons reporting it. The percentage of persons reporting having had a stroke is over 8%. Older men were less likely to report having arthritis and hypertension, but were just as likely as women to report having heart disease and diabetes.

In the United States, a study of a much older population found that about 45% of persons age 70 years or older had hypertension, 21% had heart disease, 58% had arthritis, and 12% diabetes. The prevalence of stroke in this age group was 9%. In Canada, 33% of persons 65 years or older reported having hypertension, 16% had heart disease, 47% had arthritis, and 10% had diabetes.

### **2.3    *Prevalence of Disability***

The capacity to function may be diminished if illness, chronic disease, or injury limits physical or mental abilities. The functioning capacity of older persons has important implications for work, retirement, health, long-term care needs, and for general well-being. Therefore, the goal of public policies on aging must be to focus on interventions that can increase life expectancy free of disability. The experience of countries advanced in population aging, as in Europe and North America, shows that it is possible to lower the prevalence rate of disability in older persons. There are important public health lessons to be learned from cross-national research on the determinants of functioning and participation in old age.

The SABE survey found that approximately one of every five persons 60 years and older, in the combined sample, reported having some difficulty with the basic activities of daily living (bathing, dressing, using the toilet, eating, getting in and out of bed, and walking across a room). Included in this number were those who needed assistance in order to perform an activity as well as those who were unable to do the activity at all. Elders in Bridgetown (15%), Buenos Aires (17%), and Montevideo (15%) had the lowest rate of impairments. However, in Santiago, Chile, almost 30% reported having difficulty with at least one activity of daily living. The most common limitation among both men and women ages 60 years and older was walking across a room. The variability in functional status is related to several factors, including disease profiles, rehabilitation strategies and environmental modifications available in each country. Moreover, since the data obtained by the SABE survey concern only elders living at home, it is difficult to estimate the true levels of disability without comparable data obtained from long-term care facilities or group homes.

## **2.4     *The Burden of Care in Families and Society***

Families in all countries of the Region are the primary caregivers for older persons with disabilities. Family caregiving represents a major saving for the state, and if the work of family caregivers could be quantified it would represent a major item in any state budget. Studies conducted in the United States show that caregivers dedicate an average 20 hours per week to the provision of care for older persons, and even more time when the older person has multiple disabilities. Caring for an older person with disabilities can be physically demanding, particularly for older caregivers. In addition, caregivers that lack other support are more likely to suffer from depression and other mental health problems. In the majority of the cases, caregivers need to balance employment, other family responsibilities, and caregiving responsibilities. The majority of caregivers are middle-aged women who have put on hold their personal needs to care for parents or grandparents. However, the availability of family caregivers is declining and the financial burden of caring for older parents may be too high for many lower-income families, where the paid work of all family members is deemed essential for the well-being of the family. Although the idea of family solidarity is still very strong in the Region, there is evidence of an increase of abuse and neglect of older persons who are no longer productive and who are dependent on others for their basic needs. In the SABE survey, only one-half of those reporting difficulties with a basic activity of daily living or with instrumental activities of daily living (such as shopping, transportation, cooking, and housework) reported receiving any help from families or the community.

## **2.5     *Access to Appropriate Health and Long Term Care Services***

The majority of older persons have access to a health care facility. Over 80% of those interviewed by the SABE survey reported that they visited a health care provider in the 12 months prior to the interview. However, the percentage of persons who reported needing a medication that they did not have available was over 20%. The survey provides a sketch of missed opportunities to prevent and to appropriately manage chronic and aging-related conditions by the health system.

For example, SABE data show that if an individual is diagnosed as having hypertension, that person is not always appropriately medicated, or the appropriate medication may be unavailable. Moreover, according to SABE data, other responses to hypertension are underutilized: weight loss to control hypertension varied from 23% to 45% for persons self-reporting hypertension; rigorous physical activity among persons with hypertension ranged from lows of 11% to 40% at most; and about one-third of these persons continued to smoke. There are other examples in the SABE data of missed opportunities for secondary prevention, management, and rehabilitation of older persons.

There is some evidence that the number of long-term care options in Latin America and the Caribbean is growing as fast as the population is aging. In a few countries, the percentage of persons in institutional or residential settings is already close to 4% or even 5% of the population 60 years and over. In the United States, the percentage of persons requiring nursing home care has remained steady, at approximately 5% of those 65 years and older.

Most countries lack norms and implementation of regulations to monitor quality of care. The organization of eldercare rarely includes the coordination of care across settings and levels.

## **2.6     *Public Health Responses to Aging***

The solution to the health problems of older persons requires more than access to a physician. It requires a change in the culture of health and a public health approach to health education, health promotion, early detection of problems, and appropriate resources to provide community-based rehabilitation. There is a need for human resources to be trained to understand the different health needs of an aging population. Systems should be flexible and provide coordinated services that are organized according to population needs and community resources.

Health care systems are still designed to provide acute illness care, and they lack a population-based community health orientation focused on enhancing the capacity of the individual and the community to improve health, detect early problems, and handle and manage them with the least costly and most effective approaches.

Public health in most countries of the Region has not developed an integrated community approach to promote health and well-being in the older population. Much of the work to be done requires multisectoral collaboration to ensure alleviation of poverty, healthy eating, physical and social activity, as well as a coordinated system of care for older persons.

Countries are beginning to experience the challenges posed by the care of frail older persons, and need to learn from the mistakes of those who have in the past prioritized the institutional approach to long-term care and are now searching for better models of community-based long-term care. During the past decade, the governments of Canada and the United States have explored the development of more appropriate, as well as cost-effective, community-based alternatives to nursing homes. This has led to increase funding for home care and community day-care services and has limited the growth of nursing homes. The costs related to long-term care and palliative care will become a major issue in most of the countries in the Region during the next decade. Foresight in developing appropriate community models while the demand is still

relatively low will avoid major problems during the next two decades when the demand could overwhelm the system.

### **3. A Comprehensive and Coordinated System of Care**

A comprehensive system of support should promote active aging to optimize quality of life and delay aging-dependent illnesses and disability.

The World Health Organization (WHO) has defined active aging as “the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age.”

In "A Guide for the Development of a Comprehensive System of Support to Promote Active Aging" developed collaboratively by Mexico and Canada, four agents were identified who play important roles in the promotion of active aging: the individual, family and friends, community services, and the state. Through legislation, public health policies, health care programs and services, labor force and pension policy, community funding mechanisms, and public education, the state enables other sectors and groups to support and promote active aging.

A comprehensive system of support that promotes active aging would ensure that services for older persons were based on current knowledge of effective practices that result in positive outcomes and would expand the competence of service providers. Evaluation research and surveillance should form the foundation for planning.

#### **3.1 *Establish Health Promotion Targets for Older Persons***

The study of health determinants reveal that there is a wide range of factors that contributes to the health of older adults or puts them in situations of risk. These determinants rarely exist separately and thus rarely benefit from one-dimensional solutions. Therefore, multiple sectors and partners must collaborate to address interrelated risk factors and to safeguard factors that promote active aging, giving priority to reducing social isolation, poverty, malnutrition and sedentarism.

*Social isolation and poverty.* These factors contribute to health problems and reduce the ability of older persons to access information and assistance, as needed. The social isolation of older persons is linked not only to poverty, but also to the negative stereotypes that portray them as marginal, undervalued, and burdensome. Many of the programs developed to address the social integration of younger age groups (such as literacy programs, retraining, and training for paid or unpaid jobs) are also appropriate for older persons.



What can be done? The state should give priority to multisectoral approaches to alleviating the poverty of older persons. Educate older persons to understand their rights of citizenship and promote health literacy programs targeting older persons. To make education most effective, programs should be community-specific and targeted at particular groups of elders to increase the relevance of the program and to encourage peer group networks. Education of the media and the community at large is essential for the development of a culture that welcomes and encourages the participation of elders as partners in health and community development.

*Malnutrition and sedentarism.* There is mounting evidence of the importance of active living and proper nutrition to help prevent disease and chronic conditions, boost the positive effects of rehabilitation, reduce the potential for falls and injuries, and help manage other risk factors. It has been documented that diet and exercise play a positive role in maintaining function and preventing disability.

What can be done? Screening for malnutrition and targeting the identified nutritional needs with a variety of community interventions such as senior meal programs, nutritional supplementation programs or food subsidies for the most needy are cost-effective means of preventing a significant risk factor for chronic diseases and strengthening the capacity of elders to adhere to wellness prescriptions and practices. In addition, a variety of programs are essential to promote elder participation in organized physical activities and exercise. Partnerships with community planning, transportation, culture and recreation programs need to be developed to promote physical and social activity.

### **3.2     *Establish Mental Health Targets for Older Persons***

Depression is an unrecognized epidemic in old age. The prevalence of mental health problems among elders contributes to misuse of medications, alcohol abuse, and self-destructive behavior, and reduces the capacity of the individual to receive care and manage health problems before they become disabling or life threatening. Considerable improvements have been made in the treatment of mental health problems of older persons, but there is a large gap in knowledge among mental health providers concerning these treatments. In addition, the lack of coordination between primary health care and community mental health services results in a situation where the mental health needs of most elders are often not met.

The following can be done.

- Develop local strategies designed to timely detect and treat depression, anxiety and dementia in older persons in a timely manner.
- Train mental health and primary health workers, as well as peer group counselors, to address the mental health needs of elders.
- Avoid the cost of inappropriate use of medication while making accessible appropriate therapies. The burden of depression in the overall well-being of older persons justifies an investment in building infrastructure for coordinated health care systems able to respond to the mental health needs of elders.

### **3.3 *Reorient Primary Care for the Prevention and Management of Aging-dependent Diseases and Conditions***

Primary health care systems need tools and resources to reorient or reorganize services to meet the complex health needs of older persons. The current method of organizing and financing primary health care with existing human resources cannot respond to the health needs of aging persons, even if additional resources are added to the services.

*Primary health care needs a population-based approach*, including prevention, early detection, and patient empowerment for self-care. Services need to network with community resources and other disciplines. This approach requires human resources capable of managing and treating complex health problems of older persons. Effective care also requires effective monitoring of adherence and patient education.

What can be done? Training of primary health care teams for eldercare should be considered a priority and provided with resources. PAHO has developed a Guide to Primary Health Care of Older Persons. This guide needs to be adapted to each country and supplemented with country-specific norms and policies.

In addition, training programs should be developed for teaching self-care to elders and their families to allow them to cope with chronic conditions or complex health problems. There are evidence-based educational programs that teach the necessary skills for self-care and provide models for psychological support for elders. These resources should be adapted to the needs of elders who are very poor and who have low levels of education.

*Primary health care needs to include access to essential medications* that are elder-tested and that have norms for dosage and use. In the United States, it is estimated that as many as 35% of persons over 65 years of age experience adverse drug reactions each year, and 17% of hospital admissions of persons over 65 are a result of an adverse drug reaction. This hospitalization can cost as much as \$20 billion a year and is preventable. In Latin America and the Caribbean, the quality, cost and accessibility of medications for older persons is a major challenge. Furthermore, there is a lack of training for practicing physicians and pharmacists in the way older persons respond to specific medications.

What can be done? National policies on essential medications need to be reviewed with a focus on the most appropriate drugs required by an aging population, and a coordinated effort should be made among different health sector agents to provide medications to the neediest older persons. Continuing education programs for physicians and pharmacists should include basics in geriatric medicine.

### **3.4 *Integrate Social and Health Care Services to Promote a Continuum of Support for Older Persons in Danger of Losing Autonomy***

The performance of primary health care can be improved if linkages are made to community resources relevant to health promotion, prevention, treatment, management, rehabilitation, long-term care, and palliative care of the population. Achieving an adequate range of coordinated services requires that a central entity at the local level do the assessments of needs; coordinate access and delivery of services from various sectors; establish effective information-sharing mechanisms; establish norms and standards of practice; and commit to evaluation of program effectiveness.

What can be done? Explicit guidelines and protocols for screening and assessing the physical, functional, emotional, and cognitive health of elders should be developed or adapted. Subregional forums should be conducted to share experiences among countries and to develop a common agenda for the strengthening of primary health care resources for eldercare.

At the local level, services need to be coordinated through informal networks of service providers. These networks are most effective when formal mechanisms of collaboration are developed, information is shared on a regular basis, and planning of and accountability for the use of resources to meet the needs of targeted groups of elders in the community are agreed upon. These partnerships should include organizations of older persons, nongovernmental organizations (NGOs), churches, and other voluntary organizations.

Norms and standards for programs such as adult day-care services, home care, foster adult homes, assisted living facilities and nursing homes need to be developed and implemented. The public sector, NGOs, and the private sector need to form alliances for the development of age-friendly community services. However, the state must guarantee a minimum standard of quality care to protect the dignity and well-being of disabled and frail older persons.

#### **4. Financial Resources Needed**

PAHO commits approximately US\$380,000 in regular funds for the biennium 2002-2003 to provide technical cooperation for health in aging in the Region of the Americas. In the past, the program has been able to obtain additional resources from the United States National Institute of Aging and the Novartis Foundation. The collaboration of these partners and the commitment of our national counterparts have ensured success over the past four years. However, population aging is occurring in the Region at an unprecedented rate, and we need to provide technical cooperation in a variety of specialized areas to enable countries to prepare and respond to the challenges and opportunities of aging. For this reason, additional efforts and resources are needed at both regional and national levels.

#### **5. Key Issues for Deliberation**

##### **5.1 *Investing in Older Persons***

The costs of health promotion and prevention programs targeting older persons should be compared to the cost of treatment and long-term care, as well as to the cost of mismanagement of care. The Centers for Disease Control and Prevention found that participants in an arthritis self-help course experienced an 18% reduction in pain, at a per-person savings of \$267 in health care system costs over 4 years. Each United States dollar spent on diabetes outpatient education saves \$2 to \$3 in hospitalization.

Alternatively, the cost of eldercare can be assessed in terms of missed opportunities for health promotion or mismanagement of aging-dependent diseases and conditions. Table 1 illustrates the financial, productivity, and non-financial costs of mismanaged care to elders from the perspective of older persons, their families, local health providers, and the health care system.

**Table 1. Cost of Missed Opportunities or Mismanagement of Eldercare**

	<b>Financial Costs</b>	<b>Productivity Costs</b>	<b>Non-financial Costs</b>
Older persons	Service fees (if applicable)	Lost productivity at work or home	Poor health outcomes; reduced quality of life
Family caregivers	Loss of income due to caregiving needs	Lost productivity at work or home	Reduced quality of life
Local health providers	Iatrogenic problems and resources put into inappropriate care	Reduced productivity due to time spent caring for poorly managed conditions	Frustration and reduced job satisfaction
Health care system	Cost related to poor use of emergency care	Unproductive use of resources, increase of other unmet needs	System overwhelmed by unmet needs
Overall results	Private and or public resources invested in “catching up” and most expensive “treatment” rather than on promotion, prevention, and rehabilitation	Increased disability and decrease in healthy life expectancy	Inefficiency of system; lost opportunities to postpone illness and disabilities related to age

## **5.2 Priorities to Promote Health in Longevity**

### **5.2.1 Recognize the Positive Value of Older Persons to the Family and the Community**

Working with the media to dispel the myths of aging is essential to promote images of older persons who take care of themselves, who are productive, and who contribute in a variety of ways to the development of family and society. There is a need to advocate for the promotion and protection of the basic human rights and fundamental freedoms of older persons. Longevity must become a shared value and a shared commitment.

### *5.2.2 Restructure Primary Health Services to Provide Aging-friendly Services*

Age-friendly centers may be developed as demonstration projects and as training sites in the community. It is important to start building models of aging-friendly services within the context of health care reform.

Persons providing aging-friendly services need training in the care of older persons. They also need experience working in multidisciplinary teams and should have positive attitudes toward the elderly. An aging-friendly health center promotes active aging and monitors indicators for quality, safety, accessibility, efficiency, and continuity of care.

### *5.2.3 Develop Coalitions for the Implementation of the International Strategy for Action on Aging 2002*

Increasing Pan American cooperation will become essential to support the preparations for meeting the challenges of aging societies and to assist in the implementation of the Madrid International Plan of Action on Aging 2002. Member States will benefit from technical collaboration between countries for developing appropriate responses to the International Plan approved at the United Nations Second World Assembly on Aging, in Madrid, in April 2002. A Pan American research agenda will provide the foundation for the policy response to aging and to the operational success of program development. In addition, the Region needs to place the implementation of the International Plan within the international development agenda of funding partners.

## **6. Action by the Pan American Sanitary Conference**

Based on the information presented in this document regarding the current situation of the health of older persons in the Region of the Americas, the Pan American Sanitary Conference is requested to further analyze and discuss the document with the aim of enhancing regional, national and community action in support of the human rights of older persons; to encourage the development of aging-appropriate and aging-friendly health and social services to support active aging; and to provide support for mobilizing national and international resources that will allow for appropriate implementation of the Madrid International Plan of Action on Aging 2002.

The Pan American Sanitary Conference is invited to consider the annexed resolution recommended by the Executive Committee.



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



## **130<sup>th</sup> SESSION OF THE EXECUTIVE COMMITTEE**

*Washington, D.C., USA, 24-28 June 2002*

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Annex

### ***RESOLUTION***

#### ***CE130.R19***

#### **HEALTH AND AGING**

#### ***THE 130<sup>th</sup> SESSION OF THE EXECUTIVE COMMITTEE,***

Having examined Document CE130/15, Health and Aging,

#### ***RESOLVES:***

To recommend to the Directing Council the adoption of a resolution along the following lines:

#### ***THE 26<sup>th</sup> PAN AMERICAN SANITARY CONFERENCE,***

Taking into account the importance of the Madrid International Plan of Action on Aging, to address the health problems of the older population of the Americas;

Acknowledging the shift of paradigm to healthy and active aging and the efforts made towards reducing the negative stereotypes and misunderstandings about aging since the 25<sup>th</sup> Pan American Sanitary Conference and its adoption of Resolution CSP25.R6;

Understanding the immense implications of population aging to many of the health priorities of the Americas; and

Considering the need to promote, in collaboration with other partners, a comprehensive system to support active healthy aging,

***RESOLVES:***

1. To urge Member States to:
  - (a) build on the momentum created by the 2<sup>nd</sup> World Assembly on Aging, adopt national policies and plans for the implementation of the International Plan of Action on Aging, and provide adequate support for the implementation of priority areas;
  - (b) advocate for the promotion and protection of human rights and fundamental freedoms of older persons;
  - (c) adopt appropriate health promotion priorities for older persons and develop gender-specific targets and monitoring strategies in the areas of nutritional health, physical activity, unintentional injury and fall prevention, and mental health;
  - (d) commit to increase the access of older persons, especially those that are resource poor, to aging appropriate health care and essential medications;
  - (e) promote initiatives for the development of community-based long-term care options (including supportive housing and assisted living) and regulate the provision of care to vulnerable populations;
  - (f) promote research for the monitoring and evaluation of program effectiveness;
  - (g) develop a plan for the training of primary health workers and other health professionals in the basics of health promotion for older persons and geriatric medicine.
2. To request the Director to:
  - (a) support the regional implementation of the International Plan of Action on Aging in coordination with other collaborating partners;
  - (b) assist Member States to develop healthy aging targets and indicators;
  - (c) encourage Member States to develop coordinated community-based strategies to support active aging and to disseminate information on these experiences;
  - (d) assist Member States to work toward the development of enabling and supportive environments for older persons, including regulated long-term care facilities.