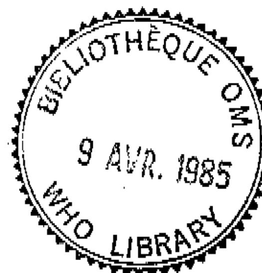
WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

INDEXED



HEALTH CARE OF THE ELDERLY

Report on a WHO Advisory Committee

Dun Laoghaire (Dublin)
22-25 March 1983

ICP/ADR 017(2)
3183E
ENGLISH ONLY
UNEDITED
LIMITED DISTRIBUTION

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1. Introduction

The Technical Advisory Committee on Health Care of the Elderly (HCE) met in October 1978, in Munich. This was an initial meeting on health recommendations made by the Committee about the priorities to be given to the European Regional Programme of health care for the elderly for the period up to the end of 1983. The second meeting of the Advisory Committee on HCE met in Dun Laoghaire, Ireland, from 22 to 25 March 1983. It was attended by 22 experts from a wide background of disciplines, together with five members of staff of the Regional Office. The meeting was the result of close collaboration between the Regional Office and the Government of the Republic of Ireland.

2. Scope and purpose

The Committee had two main objectives. The first was to review the progress that had been made since 1978, focusing in particular on the recommendations made by the Committee in Munich. The second was to make recommendations for the medium-term programme of the Regional Office for the period 1984-1989. In making these recommendations the Advisory Committee were to take into account not only their review of the progress made since the Munich meeting in 1978 but also new data and information from research studies that had been completed in the intervening period, the Regional Office's strategy for health for all by the year 2000, paying particular attention to the part that the philosophy of primary health care plays in that strategy, and the recommendations resulting from the United Nations World Assembly on Aging which was held in Vienna in 1982.

3. Health Care of the Elderly in the period 1978-1983 (incl.)

The Technical Advisory Committee on Health Care of the Elderly produced a detailed paper in 1978 but the many recommendations that were made by that Committee were considered under five main headings.

(1) Systems of care for elderly people, with particular emphasis on the means by which the most effective coordination of services could be obtained.

(2) The attitudes and beliefs about old age that prevailed both among the public and among professionals, with particular emphasis on the education that was required to influence those attitudes and behaviours.

(3) The means by which the quickly increasing amounts of information and data about elderly people could be coordinated and disseminated, with particular emphasis being given to the development of a glossary of terms that could be used at WHO meetings.

(4) Self-medication and prescribed medication, with particular emphasis on the prevention of iatrogenic disease.

(5) Prevention in old age, including screening and case finding.

The second Advisory Committee reviewed the work that had been done by the Regional Office and by other organizations, both governmental and nongovernmental, since the Munich meeting. In general it was felt that progress had been made but that it was possible to identify areas where further work needed to be done.

3.1 Systems of care

A great deal of useful work had been done on systems of care for elderly people in different parts of the Region and this had been beneficial. However, it was felt that the comparison of systems of care, although of limited value, was insufficient in itself and that it was very important for the Regional Office to encourage reviews of the research on the different interventions that were effective in preventing problems in old age or in treating those which arose, because the specific interventions that prevented or alleviated problems could be delivered by different systems of care and because it was probable that there would always be differences in systems of care in different member countries.

It was emphasized that there are dangers in focusing too closely on systems of care without considering the interventions that the particular system of care, or systems of care, were delivering to the individual elderly person. It was therefore felt to be important to complement the valuable work done by the Regional Office in this context by reviewing the research work and the professional practices which had been shown to be effective in preventing and alleviating problems such as depression, loss of fitness, pressure sores and hypothermia. It was felt that it would be very helpful to commission papers outlining the steps that could be taken to prevent and treat such problems, including sections on the most appropriate way of educating people themselves, their relatives, friends and professional helpers to complement papers that are being produced on systems of care.

3.2 Attitudes towards old age and old people

There was some evidence that the general belief that very negative attitudes towards old people prevailed in all European societies had been over-emphasized. Furthermore, a change in belief about the most effective ways of influencing negative attitudes towards old people, whether they prevailed among the public or among professionals, had occurred. In the 1970s it was believed that the most appropriate way to improve care for elderly people was to try to correct mistaken beliefs and to improve attitudes, with the objective of improving the behaviour of the public and professionals towards elderly people. More recently, however, the educational approach has changed and it is now felt to be vitally important to try to change the behaviour of the public and professionals, by teaching them the skills that can help elderly people, with the objective of changing beliefs and attitudes by demonstrating to people, and by letting them demonstrate to themselves, that many of the problems of elderly people can be prevented and that almost all of them can be alleviated by the use of the appropriate skills.

This comment links to the comment in the previous section because any approach that focuses on specific problems and the interventions that have been shown to be effective in treating or preventing those problems must be one that focuses on skills that are required.

This is not to argue that no attempt should be made to change beliefs and attitudes directly. Obviously such attempts are of prime importance but a change in emphasis is necessary with a direct approach to changing behaviour, by teaching appropriate skills, being regarded as playing a very important part in the work of the Regional Office.

3.3 Self-medication and prescribed medication

It was felt that the Technical Advisory Committee on HCE in Munich had not sufficiently emphasized the contribution that elderly people made to caring for themselves. Self-care remains, and will continue to remain, the most important and effective form of health care for elderly people. The whole topic of self-care is one that has received increasing attention by the Regional Office since the Munich meeting and self-medication forms an important part of the topic of self-care. The Advisory Committee was of the opinion that it was essential to develop this aspect of the work in the next five years.

It was felt that the problem caused by inappropriate medication prescribed by health care workers had been clearly analysed by the Regional Office, with the help of Member States, in the five years since Munich and the clear conclusion was that the major responsibility for appropriate medication and for the prevention of iatrogenic disease rested with the health care workers themselves, particularly with doctors. Although elderly people pose a greater challenge to health care workers, because of the higher prevalence of dementia in the older age groups for example, the increase in incidence of problems caused by drugs in old age could not simply be attributed to biological and psychological changes in old people themselves; a more important factor was the appropriate prescribing behaviour and adequate systems of surveillance of people on long-term medication by health care workers.

3.4 Prevention

Very important information has become available on the Gothenburg longitudinal study since the Munich meeting. This study is unique not only because of the size of the sample but also because successive cohorts are being recruited; the third cohort has been recruited recently. This is providing extremely encouraging evidence that many of the problems that occur in old age, which were formerly thought to be due to the aging process, are in fact due to other processes which can be modified and that they are therefore preventable. It seems that loss of fitness, preventable disease, and certain social changes are responsible for all or part of certain of the common problems that occur more commonly the older the age group that is studied.

Although the scope for prevention has been more clearly identified since Munich, the means of achieving prevention have not yet been clearly identified. There have been some interesting educational initiatives which have the objective of primary prevention of disease but these are difficult to evaluate. Furthermore, early intervention, through screening, has not yet been shown to be effective in preventing functional decline or admission to long-stay care. There is, however, one important aspect of early prevention and that is case finding, namely identification of unreported problems. Many elderly people have communication problems and therefore do not report the problems from which they suffer until these have reached a late stage. Systems which facilitate the reporting of problems do improve the quality of life of elderly people, in part because they encourage elderly people that an interest is being taken in them, in part because they lead to a more effective resolution of the problem. In summary, therefore, there is still no evidence that screening for asymptomatic disease is effective in old age but there is evidence that case finding for unreported problems has an important part to play in improving health in old age.

It also becomes increasingly evident that the health problems of elderly people have to be considered in a very broad context and that prevention should not be considered solely in terms of measures that can prevent specific diseases. Social problems such as poverty, housing and isolation are of equal importance in a preventive strategy, in part because they are common problems in old age, in part because each elderly person, and elderly people as a whole, needs to be considered in their social context, because it is that social context that shapes their beliefs and attitudes and which influences their behaviour in old age as well as at earlier ages.

3.5 Information

Efforts have been made to improve the collation, analysis and dissemination of information. There is evidence that information requirements are not formulated clearly and efficiently. What is needed is to focus clearly on the part that information plays in bringing about changes in professional practice and in policy making, and therefore in the quality of life of older people, and to identify means by which the information that is available can be used more effectively and efficiently. It was the view of the Advisory Committee that those who had the skills to disseminate information, for example librarians, particularly librarians working in hospitals or health services, publishers and journalists needed to be involved more closely in service planning and development.

A glossary of terms was prepared for the meeting of the Advisory Committee on HCE, following the recommendations of the Technical Advisory Committee meeting.

4. Health Care of the Elderly in 1984-89 (PLANNING FOR THE FUTURE)

It was appreciated that it was essential not simply to take this time scale as the basis for planning, but to try to take a longer term view, in accord with the Regional Office's development of plans for health for all by the year 2000.

The group's discussions on future planning were based, in part, on the review of the progress made since the Technical Advisory Committee on HCE, emphasizing the need for continuity in planning and for the development of themes for the long-time scale. However, it was recognized by the Regional Office that it was essential that the plan for the next years should not only be a continuation of the planning process that had shaped the work in the past. The reason for this is that a number of significant new ideas have developed.

5. General discussion

5.1 Information from research

A great deal of very valuable research work is being carried out and has been published in the last five years.

The evidence continues to accumulate that many of the problems that occur in old age, and have been hitherto considered as being the natural consequences of the aging process, are in fact preventable and treatable. Some are caused by the loss of fitness and the accumulation of information about the effects of disuse provides extremely strong support for a more active approach to the provision of services for elderly people and for the promotion of physical exercise and activity as a means of prevention and alleviation of problems. Many of the diseases that occur in old age have now been shown to be treatable and a proportion can also be prevented. In part the reason why there has not been a determined attempt to prevent a loss of fitness and disease has been the negative social attitudes that prevail among some old people themselves, for some of them are pessimistic about the possibilities of preventing problems and of achieving an improvement in their functional ability or quality of life.

Of great importance is the evidence come from longitudinal studies and the Advisory Committee noted with interest the decision by the World Health Organization and the International Epidemiological Association to conduct a review of the longitudinal studies currently in progress. Professor Svanborg's study in Gothenburg was felt to be of great importance because of the size of the samples involved and because of the fact that a number of cohorts had been recruited allowing not only the longitudinal study of single cohorts but also measurements of secular trends which have affected different cohorts in different ways.

Impressive though the achievements of research workers have been, the Advisory Committee on HCE identified the following weaknesses:

- there was a need for more multidisciplinary research, reflecting the multiple problems of elderly people and the true nature of service involvement with elderly people;

- there was a need for research which tried to evaluate interventions and services; too much research was still descriptive;

- there was a need to involve health economists to a greater degree in research work. The type of simple costings used by some research workers did not offer policy makers the type of information that they needed;

- there was a need to study whole populations of elderly people, rather than simply studying selected samples, such as elderly people who had been admitted to hospital, with particular attention being paid to the informal networks of support that are so easily overlooked when samples of the population are studied;

- research workers still did not pay sufficient attention to the dissemination of their findings.

5.2 Primary health care

In the last five years the Regional Office has developed its work on primary health care and this is reflected in its planning documents both for the next five years and in the development of its strategy of health for all by the year 2000.

5.3 The World Assembly on Aging

The World Assembly on Aging met in Vienna from 26 July to 6 August 1982. It discussed the papers prepared for the meeting and adopted an international plan of action on aging.

The World Health Organization contributed to the development of this plan of action and it is therefore appropriate that the recommendations in the plan are taken into account when developing WHO's own programmes, both global programmes and Regional programmes.

6. Conclusions

The Group considered a very wide range of priorities, based on the papers presented to it by participants.

Three main priorities were identified:

6.1 The development of the primary health care approach

The Regional Office has been prominent in developing concepts of primary health care for application in developed countries. A number of aspects of the primary health care principles are of particular relevance in the development of services for elderly people and it was important that member countries should bring together these two themes in health service planning, namely services for the elderly and primary health care.

The use that elderly people make of services is influenced by many factors, such as the high prevalence of impairments and resulting disabilities in old age, the low expectations of elderly people, the problems elderly people have with mobility and transport and the low level of telephone ownership among the elderly.

Although the development of an active approach to the management of disease in old age is welcomed, there was increasing concern about unnecessary investigation and treatment in people who had terminal illnesses and it was appreciated that although elderly people must not be disbarred from the benefits of technological developments on the grounds of their age. It was essential that technology be used appropriately for all very elderly people.

As numbers of elderly people are increasing faster than the amount of resources available to help them, it is of vital importance that good management be used to make sure that those resources are used as effectively and as efficiently as possible.

No single service can either meet the needs of elderly people or make effective and efficient use of its own resources unless it takes into account the contributions that can be made by other services. Joint planning and management is essential.

One of the most important aspects of primary health care is the emphasis given to participation and this poses the stimulating challenge for those involved in the planning and management of services for elderly people.

So much attention is given to the problems of elderly people's disabilities that elderly people as a group have become identified as being "a problem". This is not the case. The majority of elderly people are active and independent and only a small proportion are dependent. Furthermore, even those who are dependent on others do a great deal for themselves and without the self-care done by elderly people who are disabled and who receive some support from health and social services it would be impossible for those services to provide adequately for their needs.

Furthermore, there is no evidence that families care less well for elderly relatives than they did in times past, taking into account all the practical problems caused by demographic trends such as the decrease in family size and by social trends such as increased population mobility and increased numbers of employed women.

The challenge to health planners is to involve elderly people and their relatives in the planning and management of health services. Too often planning is done for elderly people and not with them.

6.2 Prevention

Major emphasis should be given to preventive aspects. In recent years there has been a focus on the prevention of premature death, but for older people more appropriate objectives include the following:

- the prevention of a decline in functional ability;
- the prevention of a decline of quality of life due to distressing symptoms such as pain and depression;
- the prevention of breakdown of informal support systems, notably those provided by the family;
- prevention of admission to long-stay institutional care;
- prevention of a decline in the quality of life should admission to long-stay institutional care be necessary.

6.3 Implementation

There is a considerable gap between what is known and what is done. It is vitally important that attention is paid to the implementation of research findings, both in service organization and delivery.

Attention must therefore be given to the education not only of professionals but also of economists, planners, administrators and politicians; and librarians, journalists and publishers have a vitally important part to play in this educational programme.

7. Recommendations

Future WHO and Intergovernmental Efforts: recommended priorities for responding to the need for implementation

(1) The exchange of information between health care providers and health policy makers in different countries and regions, particularly concerning model health care systems, alternative approaches to similar problems and the effectiveness of interventions;

(2) The development of simple evaluative tools for use by health care providers needing indicators of the success of programmes in health care for the elderly;

(3) The dissemination of existing research findings: a) to other researchers; and b) to busy care providers who need it to be presented in a practical and digestible form;

(4) The focus of attention on the value and means of prevention, the nature and scope of health promotion, the need for comprehensive home care, the creative use of institutional facilities and staff (including their use for respite care of people living with relatives and for day care) and on the cost-effectiveness of alternative approaches to care;

(5) The identification of the extent to which conditions associated with aging are preventable or treatable, both before and during different stages of chronological aging; this is necessary in order to encourage the informed optimism necessary to justify a further two activities:

(a) the development of effective systems for the identification and assessment of the elderly "at risk"; and

(b) the promotion (and evaluation) of health education programmes, incorporating up-to-date knowledge and using mass media, professionals, educational contexts and other authoritative sources of information and advice acceptable to older people.

The role of WHO should rather be as coordinator and stimulator of activity.

Suggested operational activities worth initiating in the short-term

(a) to identify and make direct contact with collaborating national institutes, nongovernmental bodies, researchers and health care planners who might devise and perform some of the key priority tasks; it was suggested that a register of up to 50 such collaborators be identified in each country;

(b) to re-examine its system for publication, marketing and dissemination of WHO papers (including some revised versions of papers presented at WHO meetings) so as to ensure that these papers, which include some invaluable and unique materials, are more accessible and better known to all practitioners, researchers and planners and others who could benefit from using them;

(c) to revise and promote the glossary of terms used in health care of the elderly so as to assist exchange and mutual understanding between care providers in different countries;

(d) to encourage the development of self-complete directories of model schemes and alternative approaches to assist and inform care planners facing similar problems elsewhere;

(e) to promote the publication of simple guides, flow-charts and other materials that could be used by practitioners, educators and nongovernmental bodies in informing other care providers, the lay public and elderly people themselves about the promotion of health, self-health care and the use of health care services for older people; and

(f) to develop closer links with key intermediary groups such as librarians, teachers, journalists and experts in the use of audiovisual and computer information systems.

Annex 1

WHO MEETINGS RELATED TO THE CARE OF THE ELDERLY, 1978-1982

Consultative committee on health care of the elderly
Copenhagen, 1978 (Document ICP/ADR 017)

Third meeting of directors of national institutes of gerontology
Tokyo, 1978 (Document ICP/ADR 015)

Technical advisory committee on health care of the elderly
Munich, 1978 (Document ICP/ADR 018)

Meeting with governmental and nongovernmental organizations on health care of the elderly: liaison meeting
Luxembourg, 1978 (Document ICP/ADR 016)

Technical group on the use of medicaments by the elderly
Thônex, 1980 (Document ICP/ADR 042)

Fourth meeting of directors of national institutes of gerontology
Weimar, 1980 (Document ICP/ADR 015)

Technical group on services and systems of care for the elderly
Helsinki, 1980 (Document ICP/ADR 041)

Ninth European symposium on clinical pharmacological evaluation in drug control
Schlangenbad, 1980 (EURO Reports and Studies No. 50)

Working group on appropriate levels for continuing care of the elderly
Berlin, 1980 (Document ICP/ADR 026)

Working group on the cost-effectiveness of recommending standard patterns of long-term care
Munich, 1980 (Document ICP/RPD 802(S))

Expert Committee on disability prevention and rehabilitation
Geneva, 1981 (WHO Technical Report Series No. 668)

Consultation on teaching gerontology/geriatric medicine and establishing a clearing house on curricula
Copenhagen, 1981 (Document ICP/ADR 045)

Meeting on the WHO Drug Utilization Research Group
Korcula, 1981 (Document ICP/DPM 002)

Conference on nursing and medicosocial work in care of the elderly
Cologne, 1981 (EURO Reports and Studies No. 79)

Working group to define means of prevention of disability in the elderly
Cologne, 1981 (EURO Reports and Studies No. 65)

Symposium of Journalists and Experts: "Add Life to Years"
Lyon, 1982 (Document ICP/INF 002)

Workshop on teaching gerontology and geriatric medicine
Edinburgh, 1982 (Document ICP/ADR 045)

Planning meeting for the Study on the cost-effectiveness of alternative strategies for health care of the elderly
London, 1982 (Draft Document ICP/SPM 035(1)(S))

Statistical indicators for accidents
St Etienne, 1982 (Document ICP/ADR 052(S))

Working group on the studies on prevention of accidents in the elderly
Bordeaux, 1982 (Document IRP/ADR 106-20)

Working group on housing indoor climate impact on the health of the elderly
Graz, 1982 (Document ICP/BSM 002(3)(S))

Working group on the organization of services to prevent
disability among the elderly
Sokobanja, Yugoslavia, 1982 (Document ICP/ADR 025(S))

Third meeting of investigators for the study on health care of the elderly
Jyväskylä, Finland, 1982 (Draft Document ICP/SPM 004(10))

Annex 2

WORKING GROUP REPORTS

Prevention

The group saw the period 1984-89 as a turning point because of the emerging research data on the preventability of some illnesses and impairments associated with old age. Recent information shows that personal lifestyle, as well as environmental factors in a broader sense, influence not only health but also the rate and manifestations of aging itself, within the limits set by pre-determined genetic factors. This is shown, for example, in the marked increase in longevity in some countries (especially those where limited migration has meant that little change has occurred in the genetic base of the population) and by the significant cohort differences observed.

Certain lifestyle factors (e.g. nutrition, smoking habits and alcohol abuse) have been known dramatically to influence functional characteristics like muscle strength and bone density. The practical consequence of this is that the avoidance of harmful lifestyles can be expected to offer the prospect of improved functional ability and life satisfaction in old age.

Attention has been concentrated on the deleterious effects of long-term exposure to risk factors. In the elderly, who have lowered functional reserve capacity, there is a more precipitate effect. Furthermore, the elderly are often less resistant to the acute adverse effects of such lifestyle factors (e.g. impaired respiration, lowered muscle strength).

New knowledge of aging and the old seems to show that, within wide limits, the greater use of physical, mental and emotional resources of an individual improves vitality and functional wellbeing. It has also been shown that lifestyle factors are the cause of many common disorders in the elderly, in the long term.

These facts emphasize that more attention should be paid (and more resources allocated) to research and the development of measures designed to prevent some of the negative consequences of the under-utilization of individual resources and of dangerous lifestyles. Bereavement, an event of significant social, economic and emotional change for an individual at any age, is of particular importance for the elderly. Recent studies have shown that such an event can have marked adverse biological, psychological, and medical effects, resulting in a decline in functional ability, increased mortality and morbidity. These effects can be explained only in part by the couple having shared common negative lifestyle factors in the past.

The reasons why the morbidity and mortality of bereaved spouses increase during the first year of loneliness warrants intensive study and justifies preventive and supportive measures. Other causes of loss and loneliness, such as retirement, deserve similar study and preventive and supportive reponses.

Early correct diagnosis of illness and assessment of disability is important at all ages. Given the lowered reserve functional and adjustment capacity of the elderly, this is of paramount importance in ensuring their proper treatment and prognosis. Recent studies have confirmed both under-diagnosis and over-diagnosis as being common among the elderly; this calls for alternative and more purposive use of available resources aimed at regular screening of the elderly.

In the furtherance of WHO's role in the stimulation and coordination of research and training, some basic elements of activities to prevent and postpone negative functional consequences of aging and their effects on the development of pathology must feature prominently in international programmes of research. Examples of areas for research and training are mentioned above; we would like to emphasize, in addition, the need for more knowledge of iatrogenic disorders since many of these show their most marked impact in deleterious consequences in old age as a result of the longer duration of exposure and the common coincidence of several symptoms - and therefore often of several courses of treatment - in any one individual.

Many of these points give rise to the need for greater dissemination of information about prevention to service providers and to the public.

INFORMATION

The group reviewed the objectives of information provision for the public, elderly people, health care professionals, researchers and trainers and policy-makers. It agreed upon the following Proposals for Action:

1. There is a need to identify a network of important individuals, institutions, associations and nongovernmental bodies to allow the most effective dissemination of WHO papers concerning elderly people. Each member state should be asked to nominate 20-50 key names and addresses. This will particularly allow WHO and member governments to distribute and promote papers derived from the HCE programme more effectively and efficiently;

2. A workshop should be held on methods which have been shown to be effective in health education of the elderly and of the general public. It should bring together publishers, librarians, representatives of the media and of educational institutions as well as experts in health care of the elderly, mental health and health promotion;

3. There is a need for a variety of self-complete directories, initially including a register of health education programmes, distinguishing between those aimed at different target audiences. This type of directory is a cost-effective way of ensuring that information is shared between countries and of preventing duplication and wasted effort. The Louvain proposals for a Clearing House (ref MNH/82.46) should also be adopted.

4. A workshop should be held to review the systems for publishing and dissemination of WHO papers. Other publishers should probably be involved but it was agreed that it was of vital importance that the work of the Health Information Division of WHO should more accurately reflect the technical content of the programmes in the Comprehensive Health Services Division and the work of the Disease Prevention and Control Division.

5. It is essential to draw up a set of data and yardsticks relating to specific objectives so that these can be used as indicators in the evaluation of health services for the elderly. This basis data set should be included among the routinely-collected data; it can then be used to set (and measure performance against) targets for local, national and WHO programmes for HCE. In addition, there is a need to agree upon a minimum set of simple items of information to be collected by the primary health care team in the course of contacts initiated for whatever reason by an elderly person;

The first drafts of these papers should be prepared by consultants.

6. There is a need to publish authoritative reviews of evidence about the effectiveness of interventions which can be used to prevent and treat (and support sufferers from) the following problems:

Senile Dementia
Pain
Depression
Incontinence
Falls
Sensory Deprivation
Acute confusion
Bereavement and losses
Isolation and/or loneliness
Family breakdown
Malnutrition
Iatrogenic Diseases
Loss of fitness
Pressure sores
Hypothermia

These reviews should be aimed primarily at policy-makers, research workers and trainers. There is also a need to prepare guidelines on the most effective means of translating these reviews into material aimed directly at primary health care workers and into a form designed for elderly people and the lay public. This needs to be presented in an attractive way, using visual models, flow-charts and check-lists and prepared in a way that encourages a reader, viewer or participant to consider his or her own beliefs and behaviour.

7. The WHO needs to publish an authoritative account of the scope for prevention in old age as a foundation for its preventive work in the 7th General Programme.

8. The prevention of iatrogenic disease also requires the dissemination of information:

a) this includes information from doctors to patients at the time of prescription; guidelines are needed on the education of elderly people and the public about the drugs that they receive;

b) it is essential that doctors be better educated about prescribing to elderly people and we recommend the publication of an authoritative review on the prevention of iatrogenic disease;

c) to prevent iatrogenic disease and to avoid wasteful use of resources, doctors need information about their own comparative prescribing rates and patterns. This would enable them to monitor their own practice.

9. The glossary of terms be revised and promoted widely.

10. Considerable research and evaluation will continue to be needed if factors leading to ill-health and the loss of capacity for self-care and autonomy are to be identified: much of this research must be longitudinal and comparative in nature. On-going monitoring and evaluation will also be required if the comparative effectiveness of alternative approaches and interventions is to be documented and if, thereby, unnecessary gaps between optimum fitness and morale and reduced functional capacity are to be minimized.

Annex 3

World Assembly on Aging: Vienna International Plan of Action on Aging - Recommendations for action in health care of the elderly

(a) Health and nutrition

52. While the rapidly increasing number of old people throughout the world represents a biological success for humanity, the living conditions of the elderly in most countries have by and large lagged behind those enjoyed by the economically active population. But health, that state of total physical, mental and social well-being, is the result of interaction between all the sectors which contribute to development.

53. Epidemiological studies suggest that successive cohorts of the elderly arriving at the same age have better levels of health, and it is expected that, as men and women live to increasingly greater ages, major disabilities will largely be compressed into a narrow age range just prior to death.

Recommendation 1

Care designed to alleviate the handicaps, re-educate remaining functions, relieve pain, maintain the lucidity, comfort and dignity of the affected and help them to re-orient their hopes and plans, particularly in the case of the elderly, are just as important as curative treatment.

Recommendation 2

The care of elderly persons should go beyond disease orientation and should involve their total well-being, taking into account the inter-dependence of the physical, mental, social, spiritual and environmental factors. Health care should therefore involve the health and social sectors and the family in improving the quality of life of older persons. Health efforts, in particular primary health care as a strategy, should be directed at enabling the elderly to lead independent lives in their own family and community for as long as possible instead of being excluded and cut off from all activities of society.

54. There is no doubt that, with advancing age, pathological conditions increase in frequency. Furthermore, the living conditions of the elderly make them more prone to risk factors that might have adverse effects on their health (e.g., social isolation and accidents) - factors that can be modified to a great extent. Research and practical experience have demonstrated that health maintenance in the elderly is possible and that diseases do not need to be essential components of aging.

Recommendation 3

Early diagnosis and appropriate treatment is required, as well as preventive measures, to reduce disabilities and diseases of the aging.

Recommendation 4

Particular attention should be given to providing health care to the very old, and to those who are incapacitated in their daily lives. This is particularly true when they are suffering from mental disorders or from failure to adapt to the environment; mental disorders could often be prevented or modified by means that do not require placement of the affected in institutions, such as training and supporting the family and volunteers by professional workers, promoting ambulant mental health care, welfare work, day-care and measures aimed at the prevention of social isolation.

55. Some sectors of the aging, and especially the very old, will nevertheless continue to be vulnerable. Because they may be among the least mobile, this group is particularly in need of primary care from facilities located close to their residences and/or communities. The concept of primary health care incorporates the use of existing health and social services personnel, with the assistance of community health officers trained in simple techniques of caring for the elderly.

56. Early diagnosis and treatment are of prime importance in the prevention of mental illness in older people. Special efforts need to be taken to assist older persons who have mental health problems or who are at high risk in this respect.

57. Where hospital care is needed, application of the skills of geriatric medicine enables a patient's total condition to be assessed and, through the work of a multidisciplinary team, a programme of treatment and rehabilitation to be devised, which is geared to an early return to the community and the provision there of any necessary continuing care. All patients should receive in proper time any form of intensive treatment which they require, with a view to preventing complications and functional failure leading to permanent invalidity and premature death.

Recommendation 5

Attentive care for the terminally ill, dialogue with them and support for their close relatives at the time of loss and later require special efforts which go beyond normal medical practice. Health practitioners should aspire to provide such care. The need for these special efforts must be known and understood by those providing medical care and by the families of the terminally ill and by the terminally ill themselves. Bearing these needs in mind, exchange of information about relevant experiences and practices found in a number of cultures should be encouraged.

58. A proper balance between the role of institutions and that of the family in providing health care for the elderly - based on recognition of the family and the immediate community as elements in a well-balanced system of care - is important.

59. Existing social services and health-care systems for the aging are becoming increasingly expensive. Means of halting or reversing this trend and of developing social systems together with primary health care services need to be considered, in the spirit of the Declaration of Alma Ata.

Recommendation 6

The trend towards increased costs of social services and health-care systems should be offset through closer co-ordination between social welfare and health care services both at the national and community levels. For example, measures need to be taken to increase collaboration between personnel working in the two sectors and to provide them with interdisciplinary training. These systems should, however, be developed, taking into account the role of the family and community - which should remain the interrelated key elements in a well-balanced system of care. All this must be done without detriment to the standard of medical and social care of the elderly.

60. Those who give most direct care to the elderly are often the least trained, or have insufficient training for their purpose. To maintain the well-being and independence of the elderly through self-care, health promotion, prevention of disease and disability requires new orientation and skills, among the elderly themselves, as well as their families, and health and social welfare workers in the local communities.

Recommendation 7

(a) The population at large should be informed in regard to dealing with the elderly who require care. The elderly themselves should be educated in self-care;

(b) Those who work with the elderly at home, or in institutions, should receive basic training for their tasks, with particular emphasis on participation of the elderly and their families, and collaboration between workers in health and welfare fields at various levels;

(c) Practitioners and students in the human care professions (e.g. medicine, nursing, social welfare, etc.) should be trained in principles and skills in the relevant areas of gerontology, geriatrics, psycho-geriatrics and geriatric nursing.

61. All too often, old age is an age of no consent. Decisions affecting aging citizens are frequently made without the participation of the citizens themselves. This applies particularly to those who are very old, frail or disabled. Such people should be served by flexible systems of care that give them a choice as to the type of amenities and the kind of care they receive.

Recommendation 8

The control of the lives of the aging should not be left solely to health, social service and other caring personnel, since aging people themselves usually know best what is needed and how it should be carried out.

Recommendation 9

Participation of the aged in the development of health care and the functioning of health services should be encouraged.

62. A fundamental principle in the care of the elderly should be to enable them to lead independent lives in the community for as long as possible.

Recommendation 10

Health and health-allied services should be developed to the fullest extent possible in the community. These services should include a broad range of ambulatory services such as: day-care centres, out-patient clinics, day hospitals, medical and nursing care and domestic services. Emergency services should be always available. Institutional care should always be appropriate to the needs of the elderly. Inappropriate use of beds in health care facilities should be avoided. In particular, those not mentally ill should not be placed in mental hospitals. Health screening and counselling should be offered through geriatric clinics, neighbourhood health centres or community sites where older persons congregate. The necessary health infrastructure and specialized staff to provide thorough and complete geriatric care should be made available. In the case of institutional care, alienation through isolation of the aged from society should be avoided *inter alia* by further encouraging the involvement of family members and volunteers.

63. Nutritional problems, such as deficient quantity and inappropriate constituents, are encountered among the poor and underprivileged elderly in both the developed and the developing countries. Accidents are also a major risk area for the elderly. The alleviation of these problems may require a multisectoral approach.

Recommendation 11

The promotion of health, the prevention of disease and the maintaining of functional capacities among elderly persons should be actively pursued. For this purpose, an assessment of the physical, psychological and social needs of the group concerned is a prerequisite. Such an assessment would enhance the prevention of disability, early diagnosis and rehabilitation.

Recommendation 12

Adequate, appropriate and sufficient nutrition, particularly the adequate intake of protein, minerals and vitamins, is essential to the well-being of the elderly. Poor nutrition is exacerbated by poverty, isolation, maldistribution of food, and poor eating habits, including those due to dental problems. Therefore special attention should be paid to:

(a) Improvement of the availability of sufficient foodstuffs to the elderly through appropriate schemes and encouraging the aged in rural areas to play an active role in food production;

(b) A fair and equitable distribution of food, wealth, resources and technology;

(c) Education of the public, including the elderly, in correct nutrition and eating habits, both in urban and rural areas;

(d) Provision of health and dental services for early detection of malnutrition and improvement of mastication;

(e) Studies of the nutritional status of the elderly at the community level, including steps to correct any unsatisfactory local conditions;

(f) Extension of research into the role of nutritional factors in the aging process to communities in developing countries.

Recommendation 13

Efforts should be intensified to develop home care to provide high quality health and social services in the quantity necessary so that older persons are enabled to remain in their own communities and to live as independently as possible for as long as possible. Home care should not be viewed as an alternative to institutional care; rather, the two are complementary to each other and should so link into the delivery system that older persons can receive the best care appropriate to their needs at the least cost.

Special support must be given to home care services, by providing them with sufficient medical, paramedical, nursing and technical facilities of the required standard to limit the need for hospitalization.

Recommendation 14

A very important question concerns the possibilities of preventing or at least postponing the negative functional consequences of aging. Many life-style factors may have their most pronounced effects during old age when the reserve capacity usually is lower.

The health of the aging is fundamentally conditioned by their previous health and, therefore, life-long health care starting with young age is of paramount importance; this includes preventive health, nutrition, exercise, the avoidance of health-harming habits and attention to environmental factors, and this care should be continued.

Recommendation 15

The health hazards of cumulative noxious substances - including radioactive and trace elements and other pollutions - assume a greater importance as life-spans increase and should, therefore, be the subject of special attention and investigation throughout the entire life-span.

Governments should promote the safe handling of such materials in use, and move rapidly to ensure that waste materials from such use are permanently and safely removed from man's biosphere.

Recommendation 16

As avoidable accidents represent a substantial cost both in human suffering and in resources, priority should be given to measures to prevent accidents in the home, on the road, and those precipitated by treatable medical conditions or by inappropriate use of medication.

Recommendation 17

International exchange and research co-operation should be promoted in carrying out epidemiological studies of local patterns of health and diseases and their consequences together with investigating the validity of different care delivery systems, including self-care, and home care by nurses, and in particular of ways of achieving optimum programme effectiveness; also investigating the demands for various types of care and developing means of coping with them paying particular attention to comparative studies regarding the achievement of objectives and relative cost-effectiveness; and gathering data on the physical, mental and social profiles of aging individuals in various social and cultural contexts, including attention to the special problems of access to services in rural and remote areas, in order to provide a sound basis for future actions.

(g) Protection of elderly consumers.

Recommendation 18

Governments should:

(a) Ensure that food and household products, installations and equipment conform to standards of safety that take into account the vulnerability of the aged;

(b) Encourage the safe use of medications, household chemicals and other products by requiring manufacturers to indicate necessary warnings and instructions for use;

(c) Facilitate the availability of medications, hearing aids, dentures, glasses and other prosthetics to the elderly so that they can prolong their activities and independence;

(d) Restrain the intensive promotion and other marketing techniques primarily aimed at exploiting the meagre resources of the elderly.

Government bodies should co-operate with non-governmental organizations on consumer education programmes.

The international organizations concerned are urged to promote collective efforts by their Member States to protect elderly consumers.

Annex 4

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