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INDEX

HEALTH CARE OF THE ELDERLY

Report on a Technical Advisory Committee

Munich

16-19 October 1978

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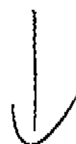

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REPORT

The Committee met in Munich, under arrangements made by the Regional Office in collaboration with the Government of the Federal Republic of Germany, from 16 to 18 October 1978. A list ... of participants is attached as Annex II.

Background

The Sixth General Programme of Work for the period 1978-1983 was adopted by the World Health Assembly in resolution WHA29.20, and one of its detailed objectives is "to collaborate with countries with a view to improving the care of the aged, preventing accidents of all types, preventing disability, and ensuring the rehabilitation of the disabled."

Responsibility for development of the programme was entrusted to the WHO Regional Director for Europe and suitable steps have been taken. There have been three meetings of directors of institutes of gerontology, and a Consultative Committee met in April 1978. This Committee was given the dual task of (1) dealing with the policy aspects of the programme and (2) identifying areas of activity which should receive priority for future development.

The Consultative Committee produced a report and the Technical Advisory Committee was made responsible for converting its priority recommendations into specific action. It was envisaged that this would be achieved through the establishment of a number of *ad hoc* technical groups, each one being entrusted with a restricted field of inquiry.

It is anticipated that Member States will pursue the development of these activities through the cooperation of national institutes and organizations.

Introduction

The meeting was opened by Dr Leo A. Kaprio, WHO Regional Director for Europe.

Dr Kaprio expressed appreciation of the generous support of the Federal Republic of Germany which had made the meeting possible. He explained that the purpose of the Technical Advisory Committee was to assist the Regional Office in planning the technical components of health care of the elderly as recommended by the Consultative Committee. These recommendations now formed part of the medium-term aims of WHO. Since health care of the elderly was one of the global responsibilities delegated to the Regional Office, the membership of the Technical Committee was deliberately international in character and he extended a special welcome to the members from Canada, Israel, Japan and the United States of America. He emphasized that members had been invited as individuals so that their knowledge and experience could be made available to WHO for development of the programme.

Dr Kaprio emphasized certain points arising from the report of the Consultative Committee:

(a) Health care of the elderly is an extremely complex matter which demands a genuine multidisciplinary approach.

(b) It was essential to recognize that it is much more than simply a medical matter - social, environmental and economic factors are all equally important.

(c) There is a need to shift emphasis from curative to preventive services and from institutional to community care, with special stress upon primary health care.

(d) There is urgent need for more effective coordination of health and social services.

Dr Kaprio drew attention to the need to foresee how the future balance of age-groups in populations would alter. Would future generations of old people be more healthy than at present? There was need to pay more attention to the quality of life of old people - simply enabling them to live longer was not enough. Countries should be looking at problems of retirement and should be evolving policies to help their populations to deal with increased amounts of leisure and, for the old, increased time after retirement.

In the light of the Consultative Committee's report, Dr Kaprio mentioned five special items:

(1) Information

(2) Service organization and management

(3) Education and training

(4) Research

(5) Coordination and cooperation.

Dr Kaprio stressed certain aspects of each of these topics.

Information

There was a need for more information based upon population studies and for exchange of information between disciplines. Better ways of analysing data should be found so that full benefit might be obtained from existing information, e.g. absolute numbers of persons in age-groups should be used as well as percentages. There was need for an up-to-date glossary of terms and for a common terminology.

Service organization and management

Dr Kaprio wished to see a review of existing services and more attempts to use population surveys as a means of ensuring that services matched the needs of communities. The WHO Regional Office for Europe had already reviewed mental health services and a similar exercise was now required in relation to the elderly.

Special attention should be directed to preventive services and those which were community-based.

The care of the dying was also a field of special importance.

Education and training

Dr Kaprio pointed out that it was widely recognized that the training for professions concerned with health care had not, in general, reflected the needs associated with the aging of populations. It was urgently necessary to formulate educational policies and training schemes for students in health and other care professions so that future workers would understand the needs of elderly people, their families and modern communities. Schemes of retraining and post-graduate education were also required for established professionals.

Equally important was the need for education of the general public including the elderly themselves to ensure a more positive attitude towards old age. Review of retirement policies and efforts at pre-retirement training were now required.

Research

Dr Kaprio referred to the huge scope for research in health care of the elderly and suggested certain broad areas for special emphasis:

(1) The definition of clinical and social predictors of health in different age-groups.

(2) Measurement of the social and economic consequences of the aging of populations.

(3) The need for research upon the health and wellbeing of extremely old persons especially females.

(4) The need for research into the ability of families to cope with elderly members.

Coordination and cooperation

Dr Kaprio emphasized the importance of ensuring that services, individuals and agencies should cooperate and coordinate their planning and delivery of services in the most effective way. Failure to do so led to wasteful duplication of effort and to gaps and deficiencies between services. Poor coordination also made it more difficult for old people and families to understand the complexities of poor cooperation between health care services.

In conclusion, Dr Kaprio stressed the need to stimulate national interest in the health care of the elderly and to encourage national research.

He then declared the Technical Advisory Committee in session and the Chair passed to Dr R.J. van Zonneveld.

Procedure

The Committee conducted its business in a generally unstructured fashion without a formal agenda.

It was agreed that the main requirement was for a very broad approach with the production of suggestions which could be applied in different countries in order to meet their most pressing needs. Reference was made to the longitudinal study which had already started in 14 countries of the Region and this was seen as an encouraging example of international cooperation. It was significant that in the agreed protocol for this study, 85% of items were non-medical, being concerned with function, patterns of living and attitudes.

It was emphasized that the widely held view that problems arising from aging of populations were exclusively a matter for developed countries was erroneous. Many developing countries already faced great difficulties with present numbers of old people, and projections to the end of this century showed that the greatest increases in numbers of over 80-year-old persons would occur in these developing countries. Thus, in Latin America, there would be an increase of the order of 250% in this age-group by the year 2000. This highlighted the need to use absolute figures since changes of this sort could be minimized or disguised by relying upon percentages.

The needs of the elderly in developing countries presented very grave problems and most of these countries had had little or no opportunity to investigate or to devise solutions. There was an urgent need to emphasize new and innovative approaches in these areas with a bias towards preventive and community services. Developing countries should be careful to avoid the overconcentration upon institutional forms of care which had characterized the services of developed countries for so long.

Needs of elderly persons

Much discussion took place about the basic needs of old people and several issues were agreed.

(1) It was misleading to consider the elderly as if they were a homogeneous group. They formed a part of all societies and they had helped to mould and build them. They should be helped to retain significant roles and to make contributions. Any tendency to think of them as "separate" was a certain way of encouraging a sense of alienation which was such a powerfully destructive influence upon morale.

(2) It was commonly believed that the care of tne elderly was mainly a matter of providing services for them, and old people were increasingly seen as passive recipients of more and more services and as consumers of more and more resources. It was necessary to emphasize that old people retained the same aims and aspirations as other groups, viz. to lead lives of independence

with positive and satisfying roles in family and community for as long as they remained fit enough to do so. When illness or disability occurred they required services which enabled them to continue to live as fully and independently as possible. Failure of society to meet these needs led inevitably to deterioration in health and happiness and to dependency with extra cost to the community.

(3) In modern society there was an increasing tendency for personal and family problems to be seen as medical issues. Thus anxiety or unease arising from work or from marital disharmony often resulted in requests for medical treatment and not infrequently the prescription of drugs, usually of a psychotropic nature. The elderly were much affected by this trend because not only did they themselves seek medical remedies but so did their families on their behalf. This phenomenon was a manifestation of the unrealistic expectations which had been created in the public mind by the great advances in medical science in the last forty years. Thus physicians had tended to make extravagant claims of their ability to deal with health problems and the public had responded by demands which often could not be met. The media of mass communication had taken up medical claims in an exaggerated fashion and further encouraged public expectation. It was important to realize that aged females were more affected by this trend than were males.

(4) Partly as a result of these trends there was an increasing tendency to offer medical remedies for problems which were non-medical,e.g. social, housing or economic problems. One result of this had been the concentration upon institutional services to the neglect of other forms of care. It was now necessary to emphasize the value of community services and to mount research studies to discover ways of meeting the needs of old people in the most effective, economic and acceptable fashion. The opinions of old people themselves should be sought although this had so far been rare. Usually,other age-groups had decided "what was best" for old people and too often the elderly had meekly acquiesced although the outcome was often not in their best interests.

(5) Another common problem had been the difficulty which physicians and other health workers experienced in thinking in terms of prevention rather than cure. Linked to this was the need to consider disability, function and rehabilitation rather than disease and traditional therapeutics. Diagnostic criteria and indications for treatment which had been developed for younger age-groups were applied directly to old people with considerable dangers of overdiagnosis and hence overtreatment. There was frequent failure to understand that symptoms and signs in old age might have quite a different significance from that in younger persons and consequently there was a risk of unnecessary and inappropriate intervention. Thus the old person who complained of feeling vaguely lightheaded and who was found to have an isolated elevated systolic blood pressure was quite liable to be treated with hypotensive drugs. The chances were that this treatment could not do the patient any good but might indeed lead to serious adverse effects. There was thus an urgent need to ensure that physicians and other health workers were properly educated in the needs of the elderly, especially in the indications for and responses to treatment.

(6) Related to this was the tendency for health workers to think mainly or exclusively in terms of disease. This trend had been accentuated by the increase in medical specialization which was due to the advances in medical science and technology. Medicine was now so complex that an individual could only be fully expert in a relatively narrow field and physicians had therefore tended to specialize in one body system (e.g. cardiology), in one technology (e.g. nuclear medicine) or even in one type of disease (e.g. oncology). While this had had remarkable benefits for some individuals,especially younger patients with a single condition, it was much less apposite for old age in which problems were usually complex amalgams of multiple pathological processes plus social, psychological and economic factors.

To attempt to manage such a complex range of problems by calling in a cardiologist, a nephrologist, a gastroenterologist and psychiatrist was not only wasteful but apt to be positively harmful. What was clearly required was a primary care physician who would see the patient as a total human being and as a member of his or her own family and community.This primary care physician had to be backed up by specialists in geriatric medicine who were specially trained and experienced in gerontology and geriatric medicine. Above all, however, was the need for doctors to work as members of multidisciplinary teams capable of coping with the complex physical, mental and social problems in optimum fashion.

(7) Up to 50% of money and resources for health care were being spent upon the 10% of the population who were elderly in developed countries. It was urgently necessary to determine how much of this huge expenditure was really necessary. For example, old people were often found in acute facilities in hospital. While they might have been admitted there because of genuine acute episodes of illness, this was not always so, and in many instances, they remained for varying periods as "bed blockers". This was usually because no alternative methods of coping with them were available (or if there were, they were unknown to the physician who had arranged the admission to the acute ward).

Not only was this wasteful and extremely expensive, it also had bad effects upon staff and the old patients themselves. For the staff (including undergraduate students of medicine and other professions), it created resentment that these "bed blockers" were not entitled to this form of care and their presence prevented the staff from doing the work they were so highly trained for. The result was an even more negative attitude towards the elderly and old age. In the case of students, this was particularly undesirable since they then tended to emerge from their training with highly biased and adverse views of older patients - attitudes which tended to persist throughout their professional careers. For the old person trapped in this "acute" setting, the outcome often was very harmful. An old lady offered only one role, that of an "ill patient" had no option but to become one and the chances of successful rehabilitation and restoration of physical and social competence diminished with each passing day of misplacement.

The development of health services

Much discussion centred upon how health care for the elderly was being provided in different countries. Despite the fact that members of the Committee came from widely differing countries and different disciplines, it was interesting to find how similar the problems appeared to be.

(1) There was a serious lack of relevant information relating to numbers of old people, their social and economic conditions and, of course, their health. Not infrequently, useful information had been collected but not made available to all who required it. In other cases, information was collected but not analyzed, or such analysis as was done was incomplete and sometimes fuller analysis would have greatly increased its value. There was need to agree on the type of information to be collected and on optimum methods of collection, analysis and presentation and to ensure that the information was distributed in an assimilable form to those who could make best use of it. Data from one country ought to be comparable with similar data from other countries. The discussion then turned to the need for standardization of terminology and it was agreed that, despite the great problems involved, the Consultative Committee's request for a glossary of terms and some form of common terminology should be met as far as possible.

(2) It was agreed that many services were not capable of meeting the needs of the communities they served. Often this was partly because they had been developed for historical or traditional reasons and had not been based upon proper epidemiological studies of needs. Most glaring of these anomalies had been the overconcentration upon institutional forms of care which were not only extremely expensive but often did not meet the true needs or wishes of old people. Detailed surveys of populations were badly needed and, arising from them, the development of appropriate services. Innovation and careful experimentation were called for and such pioneering efforts should be carefully evaluated and the results widely publicized. There was an important role here for WHO in collating information about such experiments and in the dissemination of information to Member States about them. In this way all countries could benefit from each other's experience, innovations and research.

(3) Attitudes towards old age and work with the elderly were discussed in many contexts and it was agreed that, in all the countries represented, the prestige of old age research and geriatric care were very low. This was mainly due to inappropriate education but also to lack of dissemination of information. Although much had still to be learned about aging and the optimum care of old people, the achievements of geriatric services based upon a multidisciplinary team approach were impressive. There was much to be said for setting up model services and systems of care so that people could come and see how it could be done. It was much better to say "come and see how we tackle the problems" rather than "read this paper" or "listen to this lecture". For many practical people "seeing is believing". This is borne out

by the fact that established geriatric services which practice a multidisciplinary approach are frequent hosts to visitors from their own country and abroad. The success of these services in attracting workers and students of high calibre indicates clearly that the image of care of the elderly need not remain unattractive and depressing.

(4) There was agreement that services designed to improve community care should receive emphasis and this would necessitate detailed research into the behaviour of old people and their families. Why was it that aged females consulted physicians so much more frequently and consumed such an inordinate proportion of health care resources? Why did old people tend to present problems in a medical guise when they were clearly associated with loneliness and isolation from their families? Why would one family go on cheerfully and uncomplainingly supporting an aged relative while another in apparently similar circumstances sought or even demanded immediate institutional care? Until a fuller understanding was achieved of these fundamental issues of family dynamics, services could not really be said to be meeting fully the needs of communities and detailed research was required on the optimum ways of supporting old people and their families.

Other important questions had to be answered. Thus it was important to determine how, and to what extent, industrialization was responsible for increasing the problems of families with older members. What was the effect of middle-aged women being increasingly engaged in paid employment? How could these "otherwise engaged" daughters and daughters-in-law be replaced or their reduced support augmented?

It was commonly lamented that the "three generation household" was now a thing of the past. Had it ever really been a common feature of life in many European countries as it still was, as in Japan? It was widely stated now that old people themselves did not in general wish to move in with their offspring but would prefer to live nearby and alone with such help as was necessary from families and community services. If this was true then it ought to be clearly stated so that younger generations might be spared the guilt of not having their aged grandparents under their own roof. What was the effect upon an old lady giving up her house and going to stay with her daughter? To what extent did this reduce her degree of independence and would she have been better off on her own with the necessary support being provided?

All these questions and many others required national and cross-national research by social scientists, physicians and nurses all of whom were involved in the problem. Until the results of such research were available the provision of services would remain a rather random "hit or miss" affair.

Housing for the elderly was discussed and again the decision was that more information was required. Some facts were clearly known, e.g. old people would prefer to continue living in an inconvenient and unsuitable dwelling in their familiar area, rather than move into a modern purpose-built house in an unfamiliar district.

Discussion centred also on the need to provide community services which old people could understand. For this to happen, old people had to feel themselves part of their community and indeed feel that they still had something to contribute. Where old people had come to feel alienated from their society, they were much less likely to avail themselves of existing services even when their need was great. Conversely where they had strong feelings of "belonging" they would feel the services were "their" services and make suitable use of them.

This involved subtle sociological and psychological issues which required detailed research. One factor, however, which was unanimously agreed to be important was the need that services be organized and provided in a devolved fashion, i.e. that the unit of population served should be quite small. Resources for the care of the elderly should be given to these small local units of population and old people and their families be encouraged to feel that the services existed for their benefit and reflected their needs. It was important to ensure that a bureaucratic approach be avoided. Any overcentralized service was likely to become bureaucratic and to foster a "them and us" attitude. Eventually such services would increasingly become organized and run for the benefit of the providers of the service rather than for the clients and consumers.

This discussion led on to the problems of organization and management of services and in particular to methods of securing effective coordination both in the planning of services and in their delivery. This again was an important field for research and innovation. Examples of good and bad cooperation should be documented and published.

(5) Much discussion took place on the importance of preventive services in health care of the elderly and it was agreed that, in view of the very large field involved, consideration should be confined to measures which were applicable in old age rather than enter the huge area of prevention in youth and middle age. It was agreed also that while there was an important place for primary prevention in old age (e.g. the rational use of influenza immunization for closed communities of old people in the face of an expected epidemic), emphasis should be upon the prevention of disability or of the avoidable progression of disability. This was because much of the pathology underlying disability in old age was degenerative in nature (e.g. arthrosis, arteriosclerosis and loss of special senses); therefore the chance of cure or reversal was absent or minimal. Nevertheless early diagnosis, the institution of rehabilitation measures, the provision of services and environmental adaptations could effectively help old people to remain independent for much longer than otherwise would be the case.

This point led to discussion of the value of screening in old age and it was agreed that there was no place at present for screening for presymtomatic disease or for precursor states. Multiphasic screening had not proved to be effective in middle-aged groups as judged by its effects upon mortality or morbidity rates, nor had it altered the demand for services either quantitively or qualitatively. It was therefore essential that scarce resources and trained personnel should not be diverted into this kind of activity in old age. There was, however, an important distinction between multiphasic screening and case finding which implied the earlier detection of existing and established disability through planned programmes. This type of preventive activity was now quite widely practised in many countries and although it seemed obvious that earlier diagnosis was benefical, proper evaluation and assessment of cost effectiveness were urgently needed. Such an investigation would not only determine the value of such measures but would show what was the best form of case-finding and by whom it should be done.

It was agreed that old people should be protected from ill-timed intervention. It was all too easy to upset a delicate balance by demonstrating to an old lady and her family the existence of several pathological states but if none of them could be effectively treated or relieved or if services for such relief did not exist nothing but harm could result. An independent, coping old lady could immediately be converted into an invalid. This was not, and never could be, good medical practice.

Once again the need was for well-planned research, experiment and cross-national comparisons.

In any programme of case finding it was important not to confine attention exclusively to medical aspects - loneliness, poor housing, poor diet and lack of family support all had to be sought as part of the assessment of medical and social function. Likewise the target groups for case finding had to be accurately defined - should whole populations of, say, over 75's be included or should the net be cast for certain high-risk groups? If the latter, which groups should be included? Research was required to identify the medical and social criteria which would reveal the most needy individuals and families and those most likely to benefit from intervention.

Education

Many times during the discussion, the question of education arose and it became clear that this was ineluctably mixed with attitudes. The educational need was very large and it embraced the education of the general public, those approaching old age, those already old and their families. Other key groups were health care workers, especially those engaged in primary care. Not only had the latter a large part to play in meeting the needs of the elderly and their families, but others tended to look to them for guidance. Unfortunately this guidance was often unsatisfactory. It was a sad fact that many medical schools in Europe (and elsewhere) still provided no education in gerontology or geriatric medicine; others paid only lip service to these subjects, and very few had well organized and adequate courses of instruction. This was remarkable and disturbing, having regard to the fact that physicians and other health workers all over the world would perforce be spending a larger and larger proportion of their time with the increasing numbers of old persons especially the very old. Physicians and other health workers who were well trained and confident of

their skill in gerontology and geriatric medicine would be able to respond to the challenge of their aging populations; they would derive satisfaction from their work and provide effective services. Those who were not well trained and lacking in skill and confidence would provide a poor service and be frustrated and dissatisfied.Adequate training for health professionals required urgent attention if they were going to be able to cope with public need in the last part of the twentieth century. Similar arguments applied to social workers and even to planners, architects and politicians whose ignorance was often responsible for perpetuating ineffective services and failing to introduce more appropriate ones.

Countries should therefore set up model services staffed by enthusiastic, highly motivated personnel. Others could go there to see how services should be organized and the staff of these models would act as trainers of those who would themselves become teachers.

It seemed that the time had come when governments should insist that medical schools and other health training establishments provide a broad basis in gerontology and care of the elderly. There was a need also for post-basic courses for established professionals.

Research

The subject of research arose in all the discussions and it was agreed that it was not, and ought not to be, a separate topic. It had to remain an integral part of each item. Research was needed in every field which was discussed whether it was information, services, prevention or education.

The tendency had been to concentrate upon biological and basic research but it seemed probable that here the law of diminishing return was in operation while, in the field of applied and operational research, the prospects were largely unexplored. It was essential that the best ways of determining community needs and the best services for meeting those needs should be seen as the most urgent research questions for the foreseeable future.

Medication in old age

Although it had been agreed that narrow clinical topics and disease conditions would not be individually discussed, the rapidly increasing problem of medication was repeatedly referred to. All over the world, increasing sums of money were being spent upon drugs for the elderly and it was clear that not only were these drugs often unnecessary (and inordinately expensive) but they were often given for the wrong reasons and led to adverse reactions, some of which were much more serious than the conditions for which they were prescribed. The clinical pharmacology of old age was now regarded as of great importance, and in many countries workers were studying the altered responses of the elderly to drugs. This complex research comprised careful pharmacokinetic and pharmacodynamic investigations which had shown that old people metabolized and excreted some drugs less efficiently than younger persons. Their tissues and cells were also often more sensitive to similar plasma and tissue concentrations of drugs and the required dose was therefore necessarily much lower. Problems were also common in compliance and non-compliance with prescriber's instructions and many old people indulged extensively in self-medication, including the use of "traditional medicines".

There was an important role for WHO in collecting information about current research in this field and in putting research workers in touch with each other, if possible in collaborative and complementary studies. This would enable results to be obtained most rapidly, minimize wasteful repetition and avoid gaps in research. There ought to be readily available information upon indications and contraindications for drug therapy in old age, plus information on dosage and adverse reactions. An authoritative statement on a relatively short list of essential drugs for elderly patients would be of great practical benefit.

Conclusion

The Committee achieved its aim of reaching agreement upon a relatively small number of items which were of prime importance and each of which would form the basis for the work of an ad hoc technical group.

Guidance was to be provided upon the scope of each item and upon the most desirable composition of each ad hoc group. However, it was not the task of the Committee to attempt to name the individuals but rather to offer advice to the Regional Director on the professions, disciplines and training of suggested members.

Ad hoc groups

The Committee considered the items in detail and decided to recommend that there should be five ad hoc groups:

(1) Services and systems of care for the elderly (including arrangements for optimum coordination)

(2) Attitudes and behaviour, including education

(3) Information (including provision of a limited glossary of terms)

(4) Medication in old age

(5) Prevention, including screening

Annex I provides details of each of these items with the Committee's recommendations upon general objectives, principal topics and suggestions as to the composition of each ad hoc group.

Suggested items of consideration for ad hoc groups

1. Services and systems of care for the elderly (including arrangements for optimum coordination)

General objectives

(a) Encourage the development of services and systems of care which have been shown to meet most appropriately the needs of old people, their families and communities.

(b) Enable health and social services to develop in ways which respond to changes in society, especially by methods which alleviate or overcome the problems arising from diminished availability of traditional family support.

(c) Assist developing countries to cope with the very rapid increase in their numbers of elderly persons. This will mean not only the adoption by developing countries of methods found to be successful in developed countries but also requires rejection of unsuccessful methods and, above all, thorough evaluation of new approaches. In this respect developing countries have genuine opportunities to provide models which could well be of benefit to developed countries.

Principal topics

(a) Highest priority for the identification and description of innovative approaches with assessment of their use and effectiveness.

(b) The need for effective coordination with description of the ill effects and wastefulness of inadequate coordination.

(c) The need for evaluation of services and systems of care, and especially the need to provide built-in methods of evaluation for new and developing services.

(d) Investigation of the basis upon which services are to be judged: their cost-effectiveness, their benefit to families and to the health and happiness of elderly persons.

(d) Description of existing models and systems of care emphasizing those which appear to favour the most effective coordination. Encouragement of experimental development of models which have this advantage.

Composition

General principle

Members should be selected upon the basis of their knowledge and experience and not exclusively of their professional background and training.

Suggested membership

Epidemiologist
Nurse
"Consumer" representative (possibly from a voluntary group)
Specialist in geriatric medicine
Social scientist
Planner of services
Public health administrator
Economist (co-opted as necessary).

2. Attitudes and behaviour, including education

General objectives

Review existing knowledge and conduct or suggest further national and cross-national studies upon attitudes and possibilities for changing them where needed, with special attention paid to family attitudes.

Principal topics

(a) Consideration of attitudes among the general public (including the elderly themselves) towards old age and elderly persons.

(b) Consideration of attitudes of various providers of health care, special attention being directed to those in the field of primary care. Among these attitudes, those of primary care physicians and nursing personnel (of all levels) are particularly important. It is also necessary to consider attitudes of students of these professions.

(c) Review of evidence concerning different approaches and methods for changing attitudes of the general public and professionals.

(d) Collection of evidence on the behaviour of other groups towards elderly persons.

(e) Special consideration of attitudes within families, i.e. of the family towards its elderly members and of elderly persons towards their family. Special attention to be paid to the problem of very old females and their families.

Composition

General principle

Since attitudes and attitude change are an important concern of this group, the field of education should be well represented.

Suggested membership

Two persons from education (one from adult education)
Behavioural scientist
Representative from mass media of communication
Representative from "open universities"
Expert in health education
Specialist in geriatric medicine
Nurse

3. Information (including provision of a limited glossary of terms)

General objectives

(a) Review what information is currently available in different countries and suggest what ought to be available and in what form, and how it ought to be disseminated.

(b) Consider the benefits of reanalysis of data and its new presentation.

(c) Investigate the possibilities of providing a limited glossary of terms and common terminology.

Principal topics

(a) Production of a limited glossary of terms used in information relating to health care of the elderly and investigation of the possibilities for common terminology.

(b) Determination of the demographic data which should be provided, with provision for comparability of data from different countries and from areas within countries. Investigation of the value of reanalysis and different presentation of existing information.

(c) Definition of the most useful indicators of health in terms of medical, social and economic data and data referring to the functional status of elderly persons. Investigation of relationship of environmental factors to health and function.

(d) Investigation of methods of ensuring that existing information is made available to persons and agencies which will benefit from it.

(e) Investigation of the effects of migration, both within and between countries, upon the health and wellbeing of the elderly.

Composition

General principle

The main task is epidemiological and demographic but advice and guidance will be required from those who actually work with the elderly and thus understand practices and terminology. Since much of the data will be sociological in nature, a social statistician is included.

Suggested membership

Epidemiologist
Demographer
Social statistician
Specialist in geriatric medicine
Nurse
Linguist (co-opted where linguistic difficulties arise)

4. Medication in old age

General objectives

(a) Review existing pharmacological knowledge in relation to old age.

(b) Define indications for use of drugs in old persons. Consideration of problems of "overdiagnosis", overtreatment and polypharmacy.

(c) Provide information on the most useful drugs for use in old patients.

(d) Give special consideration to the problem of the increasing worldwide prescription and use of psychotropic drugs in old age.

Principal topics

(a) Pharmacokinetics and pharmacodynamics in old age.

(b) Prescribing patterns for the elderly.

(c) Compliance and non-compliance with prescriber's instructions by the elderly.

(d) Self-medication by the elderly and their use of "traditional remedies".

(e) Adverse reactions to drugs in the elderly.

(f) Formulation of criteria for the testing and acceptance of drugs for the elderly, including those substances which are alleged to retard the aging process or reverse or alleviate the common effects of aging.

(g) Critical investigation of the claims made for so-called "rejuvenating agents", their use and their implications.

Composition

General principle

A clinical pharmacologist and pharmacist are obvious requirements but those who commonly prescribe for the elderly and who supervise drug administration are also necessary. To deal with criteria on effectiveness of substances which alter the aging process an experimental biologist will be required.

Suggested membership

Clinical pharmacologist (with special interest in old age)
Pharmacist (with special interest in old age)
Specialist in geriatric medicine
Nurse
Primary care physician
Psychiatrist with special interest in geriatric psychiatry
Epidemiologist
Experimental biologist
Economist (co-opted as required)

5. Prevention, including screening

General objectives

(a) Restrict consideration to preventive measures for persons already elderly, so as to avoid being drawn into the large field of prevention in youth and middle age.

(b) Include medical and non-medical preventive measures, e.g. those aimed at the relief of adverse psychological and socioeconomic factors

(c) Consider prevention of disability and social deterioration as well as disease.

Principal topics

(a) Review of preventive practices currently in use in different countries and of studies already carried out.

(b) Review of screening techniques in use for the elderly with evidence of their cost and effectiveness.

(c) Review of methods of evaluation and assessment of cost-effectiveness of preventive procedures.

(d) Investigation of the dangers of ill-advised and unnecessary intervention in the elderly.

(e) Consideration of the importance of accident prevention especially in the homes of old people, in institutions and on the roads.

(f) Consideration of aspects of "social prevention", e.g. the benefits of more suitable housing and adequate income maintenance for the elderly.

Composition

General principle

Members must provide a wide range of expertise and knowledge because of the multiplicity of causative factors and their mutual interdependence.

Suggested membership

Epidemiologist
Nutritionist
Physiologist
Biologist
Expert in occupational health
Specialist in geriatric medicine
Public health nurse
Specialist in adult education
Primary care physician
Specialist in social planning
Legal rights expert

ANNEX II

LIST OF PARTICIPANTS

TEMPORARY ADVISERS

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