



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



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### HEALTH AND AGING

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

Since the 25<sup>th</sup> Pan American Sanitary Conference, the Pan American Health Organization (PAHO) has urged Member States to establish national policies, plans, programs, and services for older persons with a focus on health promotion and primary health care services. During the past four years, significant gains were made in obtaining cross-national data on aging to inform policy-makers on the development of targeted policies and programs. As part of the celebration of the International Year of Older Persons and of World Health Day in 1999, PAHO and the World Health Organization (WHO) supported a health promotion approach to aging successfully and focused on the value of physical activity for preventing chronic disease and disability in old age. The United Nations is developing an International Strategy for Action on Ageing 2002, to be presented for approval at the Second World Assembly on Aging in Madrid in April 2002. The strategy responds to opportunities and challenges of individual and population aging in the first decades of the twenty-first century. The present document provides Member States with an analysis of priorities to ensure that older persons throughout the Region are able to age with security and dignity and to continue to participate in their societies and families with full rights of access to quality health care. It also provides a road map to the process of building the capacity of community programs to address the challenges and opportunities of health in aging.

The Subcommittee on Planning and Programming is requested to: (a) discuss the ways in which the policy and action framework of the regional strategy for technical collaboration on aging and health can be enhanced, and examine future approaches to health promotion and aging; (b) discuss and endorse necessary strategies for closing the equity gap in aging and health; and (c) provide support for mobilizing national and international resources that will allow for appropriate implementation of the United Nations International Strategy for Action on Ageing 2002.

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

### **1. Introduction**

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

Population aging does not need to be seen as a crisis, since healthy older persons contribute in significant ways to the development of their families and their communities. Therefore, investing in the promotion of health in aging and postponing the onset of age-related illnesses and disabilities will not only signify a success for public health in the Region, but will also contribute to the well-being of all generations.

In 1998, the Pan American Sanitary Conference passed Resolution CSP25.R6 adopting a new paradigm of active aging and requested Member States to plan for an aging society with an intersectoral approach, guided by competent human resources with a focus on primary health care and community alternatives to institutionalization.

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

The purpose of the present document is to: (a) review the situation of older persons in the Region; (b) discuss the principle obstacles to the development and implementation of a public health policy on aging in the Region; (c) stimulate discussion on the actions Members States can take to overcome these obstacles; and (d) request the Subcommittee on Planning and Programming to:

- Discuss the ways in which the policy and action framework of the regional strategy for technical collaboration on aging and health can be enhanced, and consider future approaches to health promotion and aging;
- Discuss and endorse necessary strategies for closing the equity gap in aging and health;
- Provide decisive support for mobilizing national and international resources that will allow for appropriate implementation of the United Nations International Strategy for Action on Ageing 2002.

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

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

In 1998, PAHO coordinated a multicenter Study on Aging, Health, and Well-being (SABE) in seven major cities of Latin America and the Caribbean (Bridgetown, Buenos Aires, Havana, Mexico City, Montevideo, Santiago, and Sao Paulo). A total of 10,600 statistically selected interviews of persons 60 years of age and older were completed—averaging approximately 1,500 interviews per city. SABE was made possible with the contributions of a number of funding partners, collaborating centers, and universities throughout the Region. For the first time, it was possible to collect comparable data on elders for the purpose of studying their health status and the determinants of their health.

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

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

Chronic diseases can become a significant health and financial burden to the older person, the family, and the health care system. Such chronic conditions as diabetes, heart disease, and hypertension are preventable, and the evidence shows that highly effective interventions exist and can produce significant savings to the health care system and to society in general. If not treated, these chronic diseases can lead to significant declines in functioning and the ability to remain independent.

The prevalence of chronic conditions varies in the Region. In the SABE survey, hypertension was reported by one out of every two *persons 60 years and older*; the lowest percentage was reported in Mexico City (43%) and the highest in Sao Paulo (53%). One out of five persons reported having heart disease, with the exception of elders in Bridgetown (12%) and in Mexico City (10%), where heart disease was reported less frequently. In most cities, at least one out of three older adults reported having arthritis. However, arthritis appeared to be most significant in Montevideo (48%), Buenos Aires (53%), and Havana (56%), where the proportion was closer to one out of every two elders. Diabetes was highest in Bridgetown and Mexico City, with 22% of older persons reporting it. The prevalence of stroke is over 8% in all countries. Older men were less likely to report having arthritis and hypertension, but were just as likely as women to report having heart disease and diabetes.

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

## **2.3 Prevalence of Disability**

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

The SABE survey found that approximately one of every five persons 60 years and older, in the combined sample, reported having some difficulty with the basic activities of daily living (bathing, dressing, using the toilet, eating, getting in and out of

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

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

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

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

The majority of older persons have access to a primary health care service. Over 80% of those interviewed by the SABE survey reported that they visited a health care provider in the 12 months prior to the interview. However, the percentage of persons who reported needing a medication that they did not have available was over 20%. The survey

provides a sketch of missed opportunities to prevent and to appropriately manage chronic and aging-related conditions by the health system.

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

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

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

## **2.6 *Responses of Primary Health Care to Aging***

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

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

Health care systems in most countries of the Region have not developed a comprehensive continuum of services needed to provide appropriate care at the least costly and most efficient level for older persons.

During the past decade, the Governments of Canada and the United States have supported the development of more appropriate, as well as cost-effective, community-based alternatives to nursing homes. This has led to increased funding for home care and community day-care services. Countries that are beginning to experience the challenges posed by the care of disabled older persons need to learn from the mistakes of those that have tried the institutional approach and are now searching for better models of long-term care. The costs related to long-term care and palliative care will become a major issue in most of the countries in the Region during the next decade. Foresight in developing appropriate community models while the demand is still relatively low will avoid major problems during the next two decades when the demand could overwhelm the system.

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

#### **3.1 *Vision***

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

The World Health Organization (WHO) has defined active aging as “the process of optimizing opportunities for physical, social and mental well-being throughout the life course, in order to extend life expectancy, productivity and quality of life in old age.”

There are four pillars that play important roles in the promotion of active aging: the individual, family and friends, community services, and the state.

The individual older person plays a vital role in his or her own “active aging”. Good physical health, work, and coping skills, financial resources, appropriate living environments, and mutually beneficial social relationships must be cultivated by the individual in later years, no less than in younger life. Individuals must seek and use information to make choices, adapt personal behavior to meet the demands of changing circumstances and abilities, and remain engaged in personally meaningful ways. Yet individual responsibility for optimizing quality of life can be assumed only when opportunities, resources, and viable options are made available and when individuals are empowered for self-care (for instance, through basic literacy and health education).

Family and friends provide most of the support received by elders to maintain their independence and quality of life. But family members and friends may not have the resources, time, or knowledge to be able to provide some of the care needed by older adults. Family caregivers also require support for themselves and periods of rest from caregiving.



The community as a whole has a responsibility to create a caring, supportive environment that helps individuals and families fulfill their obligations to themselves and to one another. Community services comprise a wide range of nongovernmental and voluntary agencies or associations, educational institutions, cultural centers, social service agencies, and services offered through churches.

Family and friends, voluntary and non-profit groups, and the public and private sectors play a critical role in ensuring that older adults have opportunities to take actions that will enable them to age actively. The public sector is considered the most important agent of support. Through legislation, public health policies, health care programs and services, labor force and pension policy, community funding mechanisms, and public education, the state enables other sectors and groups to support and promote active aging.

### **3.2 *Principles***

There are six basic principles that should guide the development of a comprehensive age-friendly system of support for active aging: accessibility, the centrality of the older person, a coordinated range of services, shared responsibility, equity and sustainability, and quality.

Further, a comprehensive system of support that promoted active aging would ensure that services for older persons were based on current knowledge of effective practices that result in positive outcomes, and would expand the competence of service providers. It would continually require research to inform program development and evaluation. Research and surveys would form the foundation for decision-making and evaluation.

### **3.3 *Strategies for Action***

#### **3.3.1 *Establishing Health Promotion Targets for Older Persons***

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

*Social isolation and poverty.* These factors contribute to health problems and reduce the ability of older persons to access information and assistance, as needed. The social isolation of older persons is linked not only to poverty, but also to the negative

stereotypes that portray them as marginal, undervalued, and burdensome. Many of the programs developed to address the social integration of younger age groups (such as literacy programs, retraining, and training for paid or unpaid jobs) are rarely considered appropriate or cost-effective for older persons. Evidence of the value of these programs targeted to older persons exists, however, and they have been tested and evaluated in diverse settings.

What can be done? Health education is essential to health promotion. To make education most effective, programs should be community-specific and targeted at particular groups of elders to increase the relevance of the program and to encourage peer group networks. Education of the media and the community at large is essential for the development of a culture that welcomes and encourages the participation of elders as partners in health and community development.

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

What can be done? Screening for malnutrition and targeting nutritional supplementation programs or food subsidies for the most needy are cost-effective means of bringing together multiple resources to prevent a significant risk factor for chronic diseases and to strengthen the capacity of elders to adhere to wellness prescriptions and practices. In addition, a variety of physical activity programs are important to promote elder participation in organized activities and exercise. This is a cost-effective way of improving and maintaining health and reducing the social isolation that contributes to physical and mental decline.

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

What can be done? Training of mental health workers, peer group counselors, and primary health care workers is a simple way to address the physical and mental health of elders. The cost of inappropriate use of medication and the burden of depression in the overall well-being of older persons are sufficient reasons for investing in changing the

attitudes and tools used by the health care system to respond to the mental health of elders.

### 3.3.2 *Reorienting Primary Care for the Prevention and Management of Age-related Diseases and Conditions*

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

*Primary health care needs a population-based approach*, including prevention, early detection, and patient empowerment for self-management of chronic diseases. It needs to network with community resources and other disciplines. This approach requires human resources capable of moving beyond curing acute episodes to understanding the need for a collaborative process involving the treating physician, other members of the health care team, the patient, and other partners in the management of complex health problems. Effective care also requires effective monitoring of adherence and patient education.

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

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

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

What can be done? National policies on essential medications need to be reviewed with a focus on the most appropriate drugs required by an aging population, and a

coordinated effort should be made among different health sector agents to provide medications to the neediest older persons. All physicians and pharmacists should be trained in the basic care of older persons.

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

The performance of primary health care can be improved if linkages are made to community resources relevant to health promotion, prevention, treatment, management, rehabilitation, long-term care, and palliative care of the population. Achieving an adequate range of coordinated services requires that a central entity at the local level:

- Assess elder needs to provide the appropriate kind and level of services targeted to those who need them most;
- Integrate services administratively and develop an environment that offers incentives for community collaboration;
- Coordinate access to resources provided by other sectors, such as housing, transportation, social services, sports, and recreation, and advocate for the unmet needs of the most vulnerable elders in the community;
- Establish effective information-sharing mechanisms on eldercare issues among service providers within and across disciplines and sectors to facilitate innovative and efficient use of human and technological resources;
- Establish norms and standards of practice for community care programs, home care programs, residential programs providing personal care, group homes, and nursing homes; and
- Commit to continuous quality improvement and evaluation of clinical outcomes.

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

At the local level, services need to be coordinated through informal networks of service providers, with sharing of information systems and of referral systems. It should be noted that these networks are most effective when formal mechanisms of collaboration are developed, information is shared on a regular basis, and planning of and accountability for the use of resources to meet the needs of targeted groups of elders in the community are agreed upon. These partnerships should include organizations of older

persons, nongovernmental organizations (NGOs), churches, and other voluntary organizations.

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

#### *3.3.4 Developing Partnerships for Information Sharing, Technical Collaboration, and Support*

Developed and developing countries in the Region are all experiencing the impact of the demographic transition. Sharing information on health in aging and learning from the experiences of those more advanced in the demographic transition are key to supporting the work of technical collaboration. Thus, it is important to provide new mechanisms for exchanging educational, training, and program development resources.

What can be done? The PAHO Virtual Library on Health ([www.bireme.org](http://www.bireme.org)) provides an excellent vehicle for maintaining and distributing information for decision-makers, researchers, trainers, students, and advocates. The Health and Aging portal in the Virtual Library will be a resource for all Member States, and if resources become available, the portal will become a focal point for sharing research, training, and program ideas among all partners in the Region.

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

PAHO is committing approximately US\$ 110,000 for the biennium 2002-2003 to provide technical cooperation for health in aging in the Region of the Americas. In the past, the program has been able to obtain additional resources from the United States National Institute on Aging and the Novartis Foundation. The collaboration of these partners and the commitment of our national counterparts have ensured success over the past four years. However, population aging is occurring in the Region at an unprecedented rate, and we need to provide technical cooperation in a variety of specialized areas to enable countries to prepare and respond to the challenges and opportunities of aging. For this reason, additional efforts and resources are needed at both regional and national levels.

As PAHO celebrates "100 Years of Health", its experience has focused on the public health needs of children and mothers, combating infectious diseases, and preventing chronic diseases in younger age groups. These 100 years of health have led to longer life expectancy and greater numbers of older adults. For the first time, the challenges of population aging are becoming a concern, and preparing the experience and knowledge base for longevity requires new investment. We depend on the leadership of Member States in advocating for policies, plans, and programs to extend the public health gains of the past century to the last 20 or 30 years of life. PAHO/WHO can play a significant role, if resources are available, in promoting equity in health for present and future generations of older persons in the Region.

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

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

Can we afford the cost of eldercare in the face of so many other public health priorities? The costs of eldercare should be considered in relation to the cost of prevention versus the cost of treatment and long-term care, and in relation to the cost of mismanagement of primary health care. The cost-effectiveness of prevention of chronic illness, for example, has already been documented in the United States. The Centers for Disease Control and Prevention has found that:

- Each United States dollar spent on diabetes outpatient education saves \$2 to \$3 in hospitalization; and
- Participants in an arthritis self-help course experienced an 18% reduction in pain, at a per-person savings of \$267 in health care system costs over 4 years.

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

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

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

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

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

A positive view of aging is an integral aspect of the First United Nations International Plan of Action on Ageing (1982). Working with the media to dispel the myths of aging is essential to promote images of older persons who take care of themselves, who are productive, and who contribute in a variety of ways to the development of family and society. Society invests and takes care of what it values. Longevity must become a shared value and a shared commitment.

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

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

Persons providing aging-friendly services need training in the care of older persons. They also need experience working in multidisciplinary teams and should have positive attitudes toward the elderly. An aging-friendly health center promotes active aging and monitors indicators for quality, safety, accessibility, efficiency, and continuity of care. It also works with organizations of older persons and other sectors in the community to advocate equitable access to food, shelter, education, transportation, and work for older persons.

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

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



## **6. Action by the Subcommittee on Planning and Programming**

Based on the information presented in this document regarding the current situation of the health of older persons in the Region of the Americas, the Subcommittee on Planning and Programming is requested to take the following actions:

- Discuss ways in which the policy and action framework of the regional strategy for technical collaboration on aging and health can be enhanced, and examine future approaches to health promotion and aging;
- Discuss and endorse necessary strategies for closing the equity gap in aging and health; and
- Provide support for mobilizing national and international resources that will allow for appropriate implementation of the United Nations International Strategy for Action on Ageing 2002.