

Building the foundations for health in old age in the Americas

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The demographics of aging in the Americas are well known. The United Nations has published projections showing that by the middle of this century, Latin America and the Caribbean will have 112 persons 60 years and older for every 100 persons 15 or under (1). North America will have 148 older persons for every 100 persons 15 or younger. While those numbers are impressive, the phenomenon itself represents more than just numbers.

Population aging has an impact in every dimension of life: the family, the economy, health services, and the general fabric of society. Longevity offers families the gift of multiple exchanges among three and four generations. At the same time, longevity challenges societies to adjust the cycle of work and retirement, and it impels institutions to make the necessary investments so that social service agencies and health care providers have the knowledge and skills needed to offer vital assistance across the life course.

Knowledge-based public health will need to rely on scientific knowledge that looks beyond child development and well-being of the young in order to provide the foundations for maintaining quality of life and function in old age. Planning for an aging society requires data on interrelated domains of life in old age (health, work, income, social relations) in order to guide public health functions and services in meeting the needs of an older population.

This special issue of the *Revista Panamericana de Salud Pública/Pan American Journal of Public Health* aims to contribute to this body of knowledge by presenting a series of papers covering multiple dimensions of the aging process in Latin America and the Caribbean. The majority of these studies use data generated by a multicenter project that was directed by the Pan American Health Organization (PAHO) and that was called Health, Well-Being, and Aging (*Salud, Bienestar y Envejecimiento*) (the "SABE project"). The articles in this issue are the fruits of the investment made by PAHO and its funding partners² to develop a new body of knowledge on public health and aging in the Americas.

SABE was developed as a multicenter study under PAHO's leadership. The SABE study fully engaged a group of researchers from the Region of the Americas, who worked together and took responsibility for all aspects of the study, with coordination and support from PAHO. SABE surveys were conducted in seven cities of the Region: Bridgetown, Barbados; Buenos Aires, Argentina; Havana, Cuba; Mexico City, Mexico; Montevideo, Uruguay; Santiago, Chile; and São Paulo, Brazil. Support that PAHO received from the National Institute on Aging of the United States was very important in all aspects of data management and in the training of researchers in Latin America and the United States to work collaboratively in doing cross-national research. This issue includes an article that provides a brief review of the SABE study methodology and explains how the study was conducted (2).

SELF-REPORTED HEALTH STATUS

Three articles in this issue examine self-reported health status in the SABE survey. The three pieces all agree on the usefulness of self-reported health status as an indicator as well as its strong correlation with other health measures. Wong et al. (3) do a comparative review of the indicator in all of the SABE surveys. The article presents evidence to support the use of self-reported health status as an indicator of the general health of the older population. It shows that difficulties with activities of daily living and poor memory

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are important covariates of poor health across all the cities studied. Alves and Rodrigues (4) analyzed self-reported health status in the SABE data from São Paulo, and they found a high correlation between the number of chronic diseases and self-reported health. In São Paulo an older person reporting two or three chronic diseases had a higher probability of reporting poor health than did someone without a chronic disease. In examining the older population in Bridgetown, Hambleton et al. (5) similarly emphasized the high correlation of disease indicators with self-reported health status.

MEASURING FUNCTION AND DISABILITY

The goal of primary health services adapted to older adults is to prevent or postpone loss of function and disability. However, public health indicators have frequently omitted measures of function or risk factors for loss of function and for disability. Studies in this issue have used the SABE data to analyze important aspects of health and functional capacity in old age, such as risk factors for falls, the prevalence of blindness, the relationship between living arrangements and provision of care, life expectancy free of disability, and the correlation between chronic disease and disability.

Menéndez et al. (6) analyze the statistical relation between chronic diseases and disability. Their findings show a difference in the rates of disability in two sets of cities: Bridgetown and Montevideo have lower rates of limitations in the basic activities of daily living, while Buenos Aires, Havana, Mexico City, Santiago, and São Paulo have higher rates. Age and arthritis are both positively associated with the probability of having difficulty with basic activities of daily living in all the SABE cities. Of the seven cities studied, six reported that poor health, ictus, and depression are also associated with increased probability of disability. Reyes-Ortiz et al. (7) add a new dimension to the discussion by comparing the risk factors for falls in the seven SABE cities with findings from a survey of elderly Mexican-Americans in the southwestern United States. The paper shows that the estimated prevalence of falls in the SABE study is similar to that reported by the Mexican-American population, and that both of those are higher than the prevalence found in national studies in the United States. The study demonstrates that the risk for falls increases with age and may result from the accumulated effect of multiple conditions such as diabetes, urinary incontinence, and symptoms of depression. Reyes-Ortiz et al. show that the risk of falls increases linearly with the number of risk factors. Therefore, timely prevention and appropriate interventions in the community could decrease the incidence of falls and prevent increased disability in old age.

The problem of disability impacts not only the older individual but also that person's family. Duarte et al. (8) report that 43% of older adults in São Paulo need help with activities of daily living but do not regularly receive it. Elderly persons who live with one or more adult children are more likely to receive help than those who live alone or with other persons. Family dynamics are changing due to migration and an increasing number of women working outside the home. Therefore, more social programs will be needed to look after the needs of the elderly population and to support families in their caregiving responsibilities.

Using SABE data from the city of São Paulo, Camargos et al (9) calculate an indicator of life expectancy without disabilities. While it is well known that women live longer than men, this study estimates that women 60 years of age will live only 74% of the rest of their lives free of disability, compared to 83% for men of the same age. As the population becomes older, the challenge for health systems is to ensure not only an increase in life expectancy but also an increase in disability-free life expectancy. Public policy must

also provide an equitable response to the needs of disabled older adults and their families. A case in point is the finding in the study of Pongo Águila et al. (10) that only one out of every four persons 50 years of age and older with bilateral blindness in a semirural area of Peru has access to ophthalmologic services. Age-associated cataracts are the main cause of blindness among older adults, and thus a strong contributor to disability. This is a public health challenge. In the majority of cases, postponing or avoiding blindness is feasible. Even poor countries can and should invest in public health interventions that lower the rate of disability among the old.

EQUITY IN ACCESS TO HEALTH CARE

Equity in health has been an essential value in the WHO's mission, and equity in the distribution of the resources needed to ensure health has been discussed extensively at PAHO (11). Until now we have lacked sufficient data to analyze inequities in access to health services by older adults. Two papers in this issue examine the subject of equity and access to health care. Using different models, the studies diverge in their conclusions. Wallace and Gutiérrez (12) hypothesized that inequities in access to health care within four SABE cities studied (Mexico City, Montevideo, Santiago, and São Paulo) would correspond to inequalities in the distribution of economic resources in their respective countries. Their hypothesis was disproved by showing that São Paulo has the greatest equity in indicators of access to care even though Brazil has the largest inequalities in the distribution of economic resources. The researchers found that access to care in the four cities was influenced partially by national wealth and spending on health care, but also significantly by the structure and operation of the medical care system in each city. Noronha and Andrade (13) studied six of the SABE cities and found that inequalities in access to health services are similar in all those cities. The researchers also concluded that São Paulo and Mexico City, where the inequalities in health status were higher, had greater inequalities in the utilization of health services, compared to the other cities. These two articles highlight the need for more analysis and further development of instruments and models to monitor and evaluate health-system response to population aging.

PROTECTING THE ELDERLY

The "Current topics" section of this issue begins with a look at the social protection systems for the elderly that exist in Latin America and the Caribbean (14). Subsequent articles within the same section report on initiatives from various agencies and nongovernmental organizations (NGOs) in response to the United Nations International Plan of Action on Ageing, developed during the Second World Assembly on Ageing, held in Madrid, Spain, in April 2002 (15). The pieces in this section present only a partial view of what civil society and intergovernmental agencies have contributed to the aging movement in Latin America and the Caribbean in recent years. A piece by Hoskins et al. (16) highlights the World Health Organization (WHO) blueprint for action in implementing the health priorities of the UN International Plan of Action on Ageing. The "Current topics" section also contains a comment on a study that is being conducted for the purpose of preventing the mistreatment of elderly persons (17).

This special issue underlines the importance of three networks with different missions and with enormous potential for contributing to a better future for older adults in the Region of the Americas: *Red Tiempos* (Times Network), a network of NGOs and organizations of older adults that is developing advocacy tools, services, and information for older adults in Latin America (18); *Red de Investigación del Envejecimiento en América Latina y el Caribe* (REALCE) (Network

for Research on Aging in Latin America and the Caribbean), a network of researchers with a commitment to promoting cross-national and interdisciplinary research on aging in Latin America and in the Caribbean (19); and *Academia Latinoamericana de Medicina del Adulto Mayor* (ALMA) (the Latin American Academy of Medicine of Older Adults), a network of geriatric faculty committed to strengthening the teaching of geriatrics as a medical specialty in the general curriculum of medical schools and in the continuing education of practicing physicians (20).

The articles in this issue make an important contribution to our efforts to build knowledge about health in old age in the Americas. At the same time, however, the pieces show the need for continued cross-national research as well as for the replication of studies with multiple approaches and multiple data sources.

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