Care of older people in Portugal: time for Geriatric Medicine

The challenge of ageing in Portugal

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Introduction

I would like to express my thanks for the invitation to take part in this international conference organised by the European Union Geriatric Medicine Society (EUGMS) and the Geriatric Studies Group (GERMI), of the Portuguese Society of Internal Medicine (SPMI) concerning '*The challenge of ageing in Portugal'*.

There are indeed several challenges in the process of ageing, and these vary substantially according to the culture of the country, and, within each culture, according to each individual. How they live and in which way they fulfil themselves as people, as cultural beings.

It therefore makes sense to analyse the challenges of ageing in a given country; in this case, Portugal.

Portugal is the only country in Europe that has occupied the same territory and has spoken just one language for almost a thousand years.

We Portuguese are at the extreme west of the European continent, with only the Atlantic Ocean in front of us. We have been attracted by Europe, but also by the sea and the mystery of what might lie beyond the water, where the sun hides every evening, covering the earth in a cloak of darkness.

Hence, Portuguese culture has always been a mix of reality and dreams, of certainty and doubts, serenity and astonishment.

I will bear in mind the Portuguese culture when I talk about the challenges of ageing in Portugal, a country of seafarers, squadrons and fleets, in António Nobre's poetic expression.

But first, I would like to say two things about ageing.

1. Man lives in time, both as an individual and as a species.

There is an individual chronology that goes far beyond individual physiological changes, such as the stimulating day and the restful night; or the sequence of the solstices and equinoxes and their yearly fluctuations in temperature.

This is because it can now be stated that it is the duration of the processes of chemical enzymology that creates individual biological time; for example – and this is a real case – an *in vitro* embryo, frozen at minus 170ºC for 15 years and then implanted, began to live at the same time as one of its brothers that was immediately implanted; but commenced to 'create' time, to create its own time, with a 15 year delay; because deep

freezing suspended biological time until the transfer, 15 years later, into the mother's womb.

Even in everyday situations of conception, birth, development and death, there is diachrony between the formal time of clocks and calendars and individual biological time. Analysis of the challenges of ageing depends on a proper consideration of this diachrony, as we shall see.

This diachronic relation has been recognised for thousands of years in folk wisdom. People who know me and know that I am 82 years of age say: time doesn't seem to go by for you, it seems not to go by you. To their mind, being nearly 83, I should be shaky, tired, absent minded and incapable of giving a paper at an International Conference such as this one.

There is an individual chronology, of course.

But there is also a species-specific temporal biology, which I have termed Archaeobiology, a concept that is not anti-Darwinian, but rather, supra-Darwinian.

Since I cannot reproduce my publications on the concept of archaeobiology here, I would just say that the adaptive evolution of living species and of Man, both in the classic theory of Darwin, and the neo-Darwinism of Ernst Mayr, only has meaning when considered within a temporal perspective. No adaptive alteration, no neo-speciation has ever been or will be instantaneous; nor does it ever occur in a differentiated adult body.

What does exist is a difficult and very prolonged genetic learning, such that the pressures of the ecosystem can be carried to the DNA of germ cells and appear later in the process of embryonic development, as modified somatic structures.

The human genome should thus be seen as the archaeobiological memory of the species, archived in its non-codifying part, made up of nucleotide sequences that do not transfer information for the cytoplasm to construct proteins and which are highly predominant in relation to codifying genes. The latter produce the actual body, the others memorise historic bodies and form the archaeobiology of the species *Homo*.

2. To age is to fulfil a genetic programme that can allow for a maximum lifespan of around 120 years.

Why do we live, today, for a shorter time than that granted and allowed by human genetic programming?

The answer is, exclusively because of extragenetic actions, such as homicidal or accidental violence; or because of epigenetic factors, such as alimentation and the ingestion of liquids, microbial and viral infections; and changes to the individual genetic information make-up.

We call the results of these actions diseases.

Diseases, for widely differing reasons, which I cannot detail here, eat up an individual's biological time or compete with that time, as in the case of neoplasias.

We therefore have two times in which to age.

Calendar and clock time, which are so finely tuned nowadays that they can measure the milliseconds in the life of top level athletes as they run, swim or pedal against time.

The time of cell and organ biological activity, the expression of which becomes a reality with the measuring of the speed of electrical impulse propagation along the axonal projections of the cortical neurons and the networks they form.

It is the using up of these times, synchronous or diachronous, that ages us.

We begin to age when the single cell embryo goes through the necessary biological steps to divide and become a two-cell embryo.

In vitro, each single cell embryo has its own time to duplicate the DNA and split into two cells. *In vivo*, each embryo has its own time to reach the lining of the uterus and implant itself there, to live.

So, is this the marker differentiating individual biological time?

3. Having closed this brief introduction on the biology of ageing, let us move on to the challenges of ageing in Portugal. I have identified six for the sake of brevity.

Who exactly is a senior? First challenge.

In a previous publication, I claimed that Seniors constitute a new social and age group, like childhood, adolescence or youth.

I set the onset, arbitrarily, at 65 calendar years of age, and any senior will reach a maximum of 120 years. For a centenarian – and there are increasingly greater numbers of them in Europe, and also in Portugal – the senior phase will account for 35% of their lifespan, much longer than childhood and adolescence together. And what great importance we attach to these initial age groups!

In the senior age group, as in the other age groups, including youth and adulthood, there is health, sickness and death. Road and other accidents, for example,

are the main cause of death for young people, and are fairly uncommon in the senior age group.

I would answer, then, that a Senior is any citizen, man or woman, aged over 65.

This is his/her status.

And how do Seniors live, second challenge.

To put it simply, I would say that there are three main categories:

- healthy, independent and active
- almost healthy, not very dependent, but inactive
- sick, dependent and inactive

If we accept this typology, we can move on to looking at the challenges posed for each of the three ways that a Senior lives old age.

What do sick, dependent and inactive Seniors need, third challenge.

I will reply to each, beginning with the last: the sick, dependent and inactive Seniors.

4. In Portugal, it falls to the National Health System, which is general, universal and free, to provide the solution for this problem, meeting the healthcare needs of these senior citizens.

Previously, it was the family that cared for its sick and dependent seniors. But today, in Portugal, even in rural settings, the provision of healthcare, food and hygiene to a bed-ridden senior is so demanding and rigorous that families are unable to provide it.

The network of ongoing care, recently created within the scope of the National Health Service, is very far from meeting the needs existing throughout the county. Contracts continue to be made with the *Misericórdias* and other non-profit-making institutions, but poor families living outside the big cities who take in, for example, a hemiplegic relation discharged from hospital, do not know how to attend to his/her needs.

Well-to-do families can keep their sick and dependent family member at home with them for years, in cases of Alzheimer's disease for example, contracting employees from companies specializing in providing this type of home care.

For the middle stratum, there is a choice of private, for-profit institutions, with various names – rest homes, homes, protected accommodation – which take in dependent Seniors with chronic illnesses until they die.

The cost of these solutions is high, even for families of the upper middle class; and the cost, unfortunately, is proportionate to the services provided. It is only cheap when it is of poor quality.

From time to time we hear news reports on the closure of homes for the seniors which had the capacity to shelter 40 with dignity, but which had 'piled in' 80 or more, in indescribable conditions of indignity.

The challenge of sheltering and respecting the sick and dependent seniors has not been met in Portugal by either the Social Services, the Health Service, or by not-for-profit Institutions in the Social Sector.

Discrimination, based on families' spending power, penalizes the less favoured families and is a glaring injustice for the members of this new social stratum, the Seniors, who deserve as much, or more attention than the Young.

And when the seniors, as in other social strata, begin the process of dying from an incurable illness, how are their needs met?

This fourth challenge merits discussion at some length, but I will be brief.

Over 30 years ago, Dame Cicely Saunders taught and proved that there is a new care assistance appropriate to the situation of someone who is in the process of dying, which is personalized palliative care.

Since 1996, I have insisted on the need to create personalized palliative care in Portugal, which is multidisciplinary and needs specialized practitioners.

Much has been done since then to provide such care, a care which, in the WHO definition, neither delays nor hastens the natural dying process, but which provides the person with every care that foster well-being – physical, psychological, social and spiritual well-being – right up until the end.

But high quality care is to be found in the ambit of the private companies operating in the business area that is Health; in Portugal for example, the Espírito Santo Group and the José de Mello Group, Health.

In the public sector, the oldest palliative care service is that of the Institute of Oncology, in Porto; recently a Palliative Care Service was created at the S. João Hospital with a more modern and flexible outlook.

However, given the lack of a national network to provide palliative care on the NHS, we can state that in this challenge too there is unjust discrimination between rich families, who see their Seniors die in peace, and poor families, who watch their Seniors die in pain that goes untreated and suffering that nobody takes on board or relieves.

5. Let us now move on to the second way of being a Senior – healthy or almost, independent or almost, but inactive.

This is, without doubt, the most numerous category, and is the world of the so-called retired or pensioners. Those who have ceased to work in a formal job – such as a train driver, bank employee or teacher in any level of education – retire from living; instead of merely having reformed from formal working life.

For a long time, nobody had time for these senior people for anything, if we discount the tiresome coach trips organised by the Social Services to show the streets and museums of Lisbon to the elderly from the provinces…

Until, in more developed European countries, it was discovered that these senior citizens, some of whom actually have high spending power, were an attractive business area. They became a new consumer 'segment'.

As we have seen, the ailments of these senior citizens are mainly in the joints, vision and hearing, with some cognitive disorders.

Then, out of the blue, these inactive and ailing seniors were deluged with a choice of products and services to ease away joint pain, strengthen muscles, eliminate extra fat, lower cholesterol, normalize glucose levels, give perfect vision and eliminate deafness – to give a few examples.

The SPAs promise *Sana per Acqua*, health through water, diversifying the ancient thermal springs that were for specific purposes – respiratory or skin allergies, or kidney stones, diabetes, lazy bladder, colitis, and so on. Drunk, inhaled or sprayed, the waters effected their cures. The SPAs have a beneficial effect on overall health and all the different kinds of focal ailments are also improved.

This business area has grown vastly, and has broadened its objectives, developing the concept of global health for the Senior. It is no longer a case of easing movement and providing support for certain metabolic or behavioural impairments, but rather of offering a whole other way of living old age with joy and happiness.

I will give an example that is not in Sweden, where the Seniors have been as kings for some time now, but in Portugal.

A company is going to build from scratch a large, modern, healthy village covering 113 thousand square meters so that pre-seniors and seniors can enjoy an overall better quality of life until they die.

The company representative made a statement as follows (*Público* newspaper, 8th September 2010):

‘The investment in the senior and pre-senior segment is a natural result of the ageing of the European population, of greater longevity, of this segment’s growing search for quality of life and of the growing demand for this type of product that is not met by the current supply. In addition, children nowadays are not in a situation to be able to care for and maintain their parents while living with them, given current living conditions and the smaller size of modern housing, but they want to give their parents good conditions and quality of life. The complex… is the first in our country to provide integrated physical, psychological, social, spiritual and intellectual well-being, while simultaneously preventing illness and protecting health via carefully prepared appropriate food, physical exercise accompanied by specialists, nursing care and preventative medicine, thus deferring the need for human dependence and the respective costs.

At the same time, should they need ongoing or permanent care, residents can move into the assisted living units, remaining in the same area and with the same personal relationships, the same day-to-day contact with friends and the health service workers who cared for them when they were active.’

This long citation serves to show, once again, that rich Seniors, or those with rich children, have total happiness at their disposal.

The project is eco-friendly, non-polluting, does not threaten its beautiful rural setting and will provide total satisfaction for some (few) hundred people who have the means to buy a safe and happy old age.

Once again, none of this can ever be offered to an older population who, in the main, do not have the resources to fill their time of life with health, independence and physical and mental activity.

I have nothing against the rich who use their wealth to buy a happy life as Seniors.

I know that it can never be for everyone.

But to call for social concern for all Seniors to be entitled to have healthy and active lives seems to me to be a good reply to this fifth challenge.

6. And now for the sixth challenge, which is the one for which I have the right answer ready.

How do healthy, active and independent Seniors live? That is the challenge.

My answer is this: they live as do those who are healthy, active and independent at any other age – children, adolescents, young adults, adults.

They work, they take on responsibilities, at times heavy responsibilities, and they have future projects within a time frame that is undefined right now.

Much more than young adults, Seniors live in the deep joy of Hope. Each new conquest, each personal or business success, each objective met, all are received as the fruits of Hope.

Manoel de Oliveira conceives a new film at 102 years of age and when he sees it shown in Cannes or Venice, he will be glorifying Hope.

To hope is the great verb of life. But only the Senior conjugates it in full.

There are increasingly more of us healthy, independent and active Seniors, but we are still few. We account for around 25% of the two million Seniors in Portugal; another 25% will be less healthy and with some dependency, and inactive or not very active.

And one million Seniors need the support of family, social services and a National Health Service that is truly general, universal and free at time of use. With ongoing care and palliative treatment.

7. And how does one become a Senior who is in full possession of his physical, mental and social capacities?

Each person has a normal genetic substrate, and the future depends on the interplay with epigenetic factors and the way that each decides to deal with those factors.

To win good quality old age is a decision made in our youth, and the young person is not always well-informed as to the consequences of his decisions on the quality of his life as a senior.

For example, a young man who decides to drink too much alcohol in bars and various night spots will easily grow into an adult who suffers from alcohol abuse and will end up dependent on alcohol; he will die before he reaches old age; or will be a sick, dependent and inactive senior, going from hospital to hospital, abandoned by his

family, until ruptured oesophageal varices put an end to the suffering of an old age that he ruined in his youth.

The same can be said of the decision to take up smoking at the age of 14, to eat excessively at 12, to inject heroin at 20, to spend many hours every day playing poker on the computer or watching video after video as if the real world did not exist.

When one hears the clinical history of a 50-year-old man who has had a stroke, or heart attack, diabetes, obesity, lung cancer, one can easily note the wrong decisions made in handling the epigenetic factors that eat up the body's time, alter it in structure and function and lead it to an early death.

So, the challenge of managing to live, after the age of 65, as a healthy, independent, active, and thus happy senior, is won in childhood, in youth, and in the first years of adult life.

After this time, there is nothing, or hardly anything, that can be done for someone to be a happy senior.

We can give an alcoholic a new liver, but we cannot correct the damage that alcohol and cirrhosis have done to his body over the years.

Don't for a minute think that it is with organ transplants, namely heart transplants, that one can create healthy, independent and active Seniors. We all know that changing the engine is not enough to give you a new car.

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Conclusion

Health education and the promotion of decisions and behaviours that will create a current and future state of health must be priorities in a country, such as Portugal, which has so many other conditions conducive to its citizens reaching 100 years of age: little air pollution in most of its territory, abundant and good quality water, hundreds of kilometres of beaches that can be used six months of the year, relatively mild winter temperatures, good fish for a traditional and intelligent national cuisine. Good wines, which are very healthy when drunk in moderation throughout life.

I will close with a proposal that should be taken up as a permanent national objective:

To mount an effective campaign against alcoholism – through education in the family and at school. And through social censorship instead of tolerance.

To make an effective fight against obesity – through education in the family and at school. And through social censorship.

To cut to the minimum the habit of smoking – in the family and at school. Reinforcing social censorship.

This is the great tripod sustaining a better quality of life for our Seniors who will not age or die before their time.

This is a big question, the biggest public health question in Portugal.

But it is not only a question of the State.

It is also a great challenge for all of us, as responsible and free citizens.

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