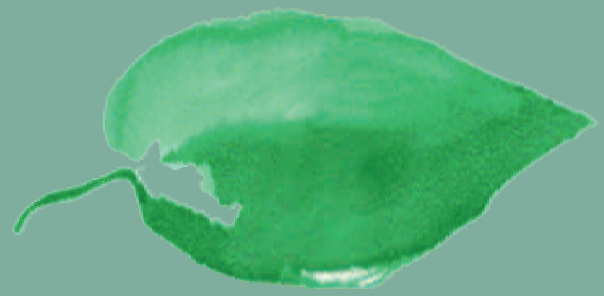
NATIONAL PROGRAMME FOR THE HEALTH OF THE ELDERLY



DIRECTORATE-GENERAL OF HEALTH

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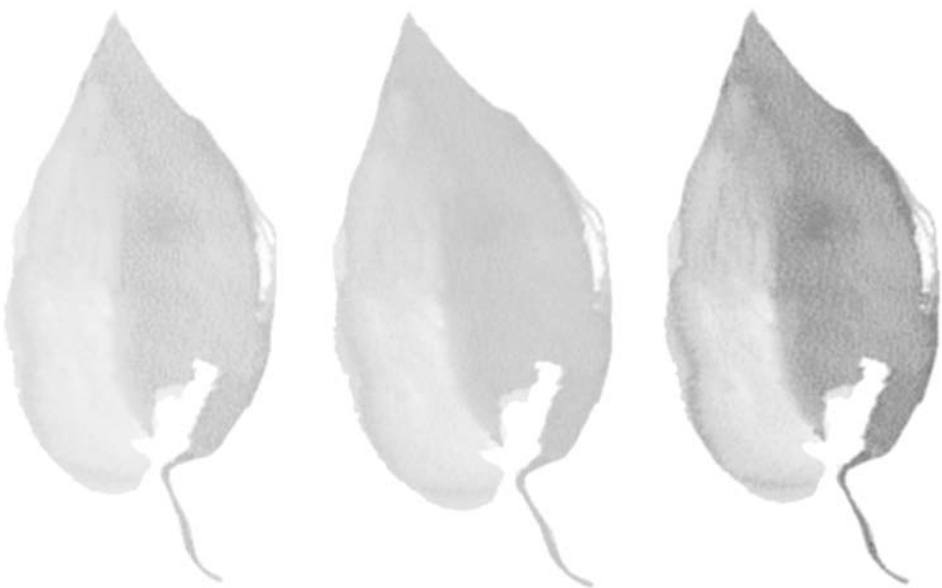
DEPARTMENT OF HEALTH ALONG THE LIFE CYCLE AND IN SPECIFIC ENVIRONMENTS

NATIONAL PROGRAMME FOR THE HEALTH OF THE ELDERLY



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ÍNDEX

INTRODUCTION

Demographic changes over the last century have brought about alterations and even in some cases an inversion, in the numbers within the various age groups, reflecting the ageing of the population and presenting new challenges for governments, families and society in general, challenges for which they were not prepared.

To maintain health, autonomy and independence for the longest possible time, therefore, constitutes, today, a challenge to the individual and society in general, and has a significant impact on the economic development of each country.

The question, therefore, is to view ageing as a life-long process requiring greater promotion of health and autonomy, from which moderate and regular practice of physical exercise, healthy nutrition, non-smoking, moderate alcohol consumption, the promotion of safety factors and maintenance of social participation are indissociable. Similarly, it is important to reduce incapacity with a view to early global recovery, by means adequate to the individual and the family and to involve the community with its existing resources and its ever-increasing capability for promoting action among the population.

The promotion of healthy ageing involves multiple sectors: health, education, social security and employment, economy, justice, planning, rural and urban development, housing, transport, tourism, new technologies, culture as well as those values defended by each society and upheld by each individual.

Thus, human ageing may be defined as the process of progressive change in an individual's biological, psychological and social structure, beginning before birth and developing throughout life.

Ageing is not a problem but a natural part of the life-cycle and, ideally, should be an opportunity to live healthily and autonomously for as long as possible. This implies an integrated change of behaviour and attitude from the general public, in the training of health professionals and in other areas of social intervention, an adaptation of health and support services to the new social and family circumstances associated with individual and demographic ageing and an environmental adjustment to cope with the frailties that most frequently accompany advanced age.

Those policies, aimed at older people, capable of improving their autonomy and independence, accessible and sensitive to their most pressing needs and those of their families, result in a reduction of costs, prevention of dependency and the humanisation of care and, also, adjust to the diversity which characterises individual and demographic ageing.

From an individual perspective, in order to achieve a health system that responds to the needs of an ageing population, the provision of health care and social support centred on pluridisciplinary teams and adequately trained human resources is indispensable, as is an element for global recovery and accompaniment through continued, long-term care.

To be able to live independently in their own homes for as long as possible must be the aim of every individual and its realisation a collective responsibility.

From the collective viewpoint, since the ageing process affects all human beings, it necessarily involves all social sectors, demanding their intervention and co-responsibility in the promotion of the autonomy and independence of the elderly, as well as the participation of their families and other care providers, friends, volunteers and health professionals. This fact represents an enormous challenge and responsibility for the health services, particularly in the area of primary health care, in the implementation and improvement of community intervention strategies that meet the specific needs of the population.

The National Programme for the Health of the Elderly seeks to achieve these objectives.

The Programme is complimentary to measures currently under development by other National Health Programmes, within the scope of the National Health Plan 2004 -2010.

Nevertheless, it falls upon the Regional Health Administrations to adapt, through their Plans of Action, the strategies consigned in the present Programme, developing them while allowing for already existing activities, improving and adjusting them to the guidelines to be laid down in due course by the Directorate General of Health, within a multidisciplinary and integrated perspective and with constant regard to the assessments to be carried out meanwhile.

The implementation of the present Programme requires the active participation, in the respective spheres of action, not only of the central institutions of the Ministry of Health and the Regional Health Administrations but also of the services and institutions depending upon other Ministries, non-governmental organizations, citizens' associations and scientific societies.

FRAMEWORK

Prolonged life expectancy, in conjunction with a significant decline in fecundity, has led to the ageing of the population.

In effect, the progress achieved by development in general and by the health sciences in particular has contributed decisively to an average increase in life expectancy of 30 years in the course of the XX[I] century. This increase in longevity, from which Portugal is not exempt, albeit to a lesser extent than some European countries, has a deep impact on public health.

Portugal has an elderly resident population[1] estimated at 1 709 099[II] which represents 16,5% of the total population, with a geographic distribution characterised by more inland ageing than littoral. Life expectancy at birth in Portugal is 80.3 years[III] for women and 73.5 years for men.

The existing demographic ageing process, associated with the changes in social and family structures[2] and behaviour, will determine new health needs in the forthcoming years, presenting huge challenges to health systems, in respect not only of ensuring accessibility and quality of care, but also the sustainability of the systems themselves, demanding that the increase of life expectancy at birth corresponds to an increase of life expectancy "with health" and without deficiency.

As to the perceived state of health[IV] of the elderly Portuguese population, 49% of the people between the ages of 65-74 and 54% of 75 year-olds and over, consider their health to be bad or very bad. In a recent study[V], whilst 12% of the 65 year-olds and over who were interviewed stated that they needed help with daily tasks, 8% stated that in the previous year, they had suffered, at least, one domestic or leisure accident. Moreover, while 52% of the older people interviewed declared that they lived in the company of one person, 12% stated that they lived alone.

1. For the purpose of statistics, elderly people are normally related to groups of specific ages, e.g. people of 60 years-of-age or more, depending on cultural and individual factors. (Cf World Health Organisation: A life course perspective of maintaining independence in older age. WHO's Ageing and Health, Geneva, 1999). There does not exist, however, any consensus as to the age limits of the large groups which must be the subject of ageing analysis. (Cf. INE As Gerações Mais Idosas. Série de Estudos nº 83. Portugal. Lisbon, 1999). In this document, men and women of 65 or above are considered older people.
2. Single elderly families, especially those of single women, have increased over recent years. Ibid

Insofar as seeking health care(vi) is concerned, the indicator of medical consultations in the last three months, showed an increase in consultations by the over-65s, more specifically by those above 85 years of age. This increase corresponds to 22% between 1987 and 1999, which justifies, indeed makes compelling, the progressive provision of adequate health care for the advanced old.

Good health[3] is essential if older people are to maintain an acceptable quality of life[4] and continue to contribute to society[VII] since people who remain active and healthy not only remain independent but are also an important resource for their families, communities and economies[VIII].

In reality, the domains of health and quality of life are complementary, partially overlapping, it being important to distinguish between the normal ageing[5] process and that which is strongly affected by prejudicial environmental factors, harmful lifestyles and states of health.

The concept of active ageing[6], recommended by the World Health Organization[IX] and supported at the II World Assembly on Ageing[7], derives from a variety of influences, or determinants that contemplate not only individuals but also families and nations. The strong evidence of what determines health suggests that all these factors, as well as the ones that derive from their interaction, constitute the referential quality indicators in respect of the ageing of people and populations.

If it is true that the individual's biological, genetic and psychological determinants contribute to the ageing process and to the occurrence of diseases throughout life, the fact should not be overlooked that in many cases the decline in performance associated with ageing is closely linked to external factors, behavioural, environmental and social. Depression, loneliness and isolation[8] affecting many of the elderly are important examples of this.

Consequently, the health of the elderly results from past lifestyles, exposure to living environments and the health care provided[X] and the quality of their life is greatly influenced by their capacity to retain their autonomy[9] and independence[10].

Nevertheless, although enormous medical progress has taken place over the last decades, in reality the final years of elderly people are frequently accompanied by increasing disease and incapacity that might often be prevented.

Health promotion[11] and preventive care increase longevity, improve the health of the elderly, enhance their quality of life and help to optimize society's

3. Health is a resource for everyday life not merely the object of living: it is a positive concept emphasizing personal and social resources as well as physical capabilities. (Cf. Organisation Mondiale de la Santé. Glossaire de la promotion de la santé. Genève 1999)

4. Quality of life is an individual perception of his or her position in life in the context of the culture and value system where they live and in relation to their goals, expectations, standards and concerns. It is a broad-ranging concept incorporating in a complex way a person's physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features in the environment. (WHO, 1994) (Cf World Health Organization, Men, Ageing and Health, Achieving health across the life span, Geneva 2001)

5."Normal Ageing" represents the universal biological changes that occur with age and are unaffected by disease and environmental influences. (Cf ibid)

6. Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. (Cf. WHO, Active Ageing, A Policy Framework. A contribution of the WHO to the Second United Nations World Assembly on Ageing, Madrid, Spain, April, 2002)

7. Held in Madrid from 8th to l2th April 2002

8. Elderly people living alone, in general, have the worst living conditions and, of these, men are in a more disadvantageous position (Cf. INE As Gerações Mais Idosas, Série de Estudos Nº 83, Portugal, Lisbon, 1999)

9. Autonomy is the perceived ability to control, cope with and make personal decisions about how one lives on a day to-day-basis, according to one's own rules and preferences. (Cf. WHO, Active Ageing, A Policy

resources[12]. The effectiveness of the prevention of health risk factors common to several incapacitating pathologies of long term progression has, in fact, been proven and makes the coordinated action of all parties involved a priority, in order to improve care with good nutrition, discourage excessive alcohol consumption, end or reduce smoking, encourage the regular practice of physical exercise[12] [13] and control stress factors.

Given the behavioural determinants of active ageing throughout life, the adoption of more physically beneficial lifestyles and greater participation in self-care promotion will be fundamental to a healthier and longer life, thus disproving one of the most common negative myths linked to ageing – that the elderly cannot change their habits.

Hence, the primary, secondary and tertiary prevention of deficiency, incapacity, disadvantage and dependency among older people, allowing for age and gender, constitutes a priority for the health sector, indispensable if the maximum autonomy and independence of this sector of the population are to be maintained for the longest possible time; necessitating a change in the mentality and attitude of the general public with regard to ageing and intervention at all levels of society to address issues relating to the necessary adaptation and improvement of environmental conditions.

On the other hand, whether from the physiological or psychological point of view, as we age, health determinants[14] are also linked to gender[XII]. What must be considered, therefore, are those factors which determine, for example, that, in relative and general terms, men may expect to live longer without any long-term physical disability, despite the fact that life expectancy is higher in women.[XIII]

An approach that respects the distinction of gender, takes into account not only the biological differences between men and women but also the construction of the social roles that will shape the identity of each throughout life. That is to say, an approach to the subject according to gender gives a clearer picture of the differences in men and women's social and health requirements and determines their living and ageing processes.[XIV]

Culture and gender, being transverse determinants(xv), influence the other factors of active ageing: the way in which the generations inter-relate and also their behaviour regarding health and disease.

Framework. A contribution of the WHO to the Second United Nations World Assembly on Ageing, Madrid, Spain, April, 2002)

10. Independence is commonly understood as the ability to perform functions related to daily living – i.e. the capacity of living independently in the community with no and/or little help from others. Daily living activities (DLAs) include, for example, bathing, eating, using the toilet, and walking across the room. The instrumental daily living activities (IDLAs) include activities such as shopping, housework and meal preparation (Cf. ibid)

11. Health promotion is the process of enabling people to increase control over, and to improve, their health and represents a global process which comprehends not only those actions that envisage reinforcing the individual's aptitudes and capacities but also the measures that are undertaken to change social, environmental and economic conditions. (Ottawa Charter for Health Promotion, Geneva 1986)

12. Only 2.4% of the elderly practice regular physical exercise. (Cf. INE As Gerações Mais Idosas, Série de Estudos Nº 83, Portugal, Lisbon, 1999)

13 For the elderly, exercise, respecting the limits of their physical capacity and under medical supervision, reduces the loss of bone mass and increases muscular mass and strength. It may also improve mental health and contribute to a state of general well-being. (Cf. Paulo. Bugalho, Margarida. Pereira Miguel, José For Better Health in Europe, Report with the support of the European Commission, Lisbon. Instituto de Medicina Preventiva da Universidade de Lisboa, Portugal, 2001),

14. Health determinants are the range of personal, social, economic and environmental factors which determine the health status of individuals or populations. They are multiple and interactive. (Cf. WHO/HPR/HEP/98.1. Glossaire de la Promotion de la Santé, Genève, 1999)

In those societies in which is it culturally common to associate ageing with illness, in general, less importance is given to prevention and early detection. As a result, adequate health care for this age group is neglected and the resources are aimed, preferably, at the sector of the adult population regarded as productive.

The purpose of the present Programme is to reflect upon the preoccupation of the health sector with the urgent need to dismantle the negative stereotypes linked to ageing, as well as to change the mentalities and attitudes that still condition a more satisfactory approach to the problems, rights and needs of older people.

The non-communicable and, by their insidious nature, long-term illnesses, incapacitating and with a tendency to become chronic, are the principal causes of morbidity and mortality in older people at enormous individual, family and social cost. It is known, however, that a great number of the complications connected with illnesses can not only be delayed at their onset but also reduced.

Within the context of the chronic pathology that, in general, most affects older people, sight, hearing impairments and oral health problems are usually undervalued, which has major negative repercussions, namely in respect of their isolation and nutrition, as well as on their bio-psycho-social[15] balance.

The prevalence of Parkinson's disease increases from 0.6% at the age of 65 to 3.5% at 85 and above, becoming one of the most common chronic neurological-degenerative diseases in the elderly[XVI].

Reference should also be made to the increase of dementia[xvii] from 1% at the age of 65 to 30% at 85, doubling that figure every five years between the ages of 60 and 95, with women outliving the men, despite the fact that the incidence of Alzheimer's disease is much more significant in the female .

Similarly, there is a significant increase on stroke: from 3% at 65 to 30% at 85 and above. Within the European Union, stroke is a significant cause of death and serious impairment[XVIII]. It should be noted that cardiovascular disease sufferers have a higher risk, estimated at about 30%, of developing dementia, including Alzheimer's.[XIX]

In Portugal, the principal causes of death from age 64, in both men and women, are the circulatory system and malign tumours, particularly among men,[16],

15. "Suicidal death is more frequent in the over-65s." (Cf. Paulo. Bugalho, Margarida. Pereira Miguel, José For Better Health in Europe, Report with the support of the European Commission, Lisbon. Instituto de Medicina Preventiva da Universidade de Lisboa, Portugal, 2001),
16. "Prostate cancer is presently the second cause of death among men in the EU". (Cf. Paulo. Bugalho, Margarida. Pereira Miguel, José For Better Health in Europe, Report with the support of the European Commission, Lisbon. Instituto de Medicina Preventiva da Universidade de Lisboa, Portugal, 2001),

though observation has shown an increase, in both sexes, in diseases of the respiratory system[XX]. It should be noted that Portugal is, within the European Union, the country that holds the highest mortality rate both in male and female, over the age of 65[XXI].

Mortality over the age of 64

Cause of death (per 100 000)	Men		Women	
	1996	1999	1996	1999
Diseases of the circulatory system	2851.3	2585.2	2629.5	2390.7
Malign Tumours	1330.1	1373.9	675.8	674.8
Signs, symptoms and badly defined affections	695.9	658.3	662.9	658.3
Diseases of the respiratory system	688.6	885.4	386.3	507.2
Diseases of the digestive system	284.5	249.0	145.1	137.3
External causes	189.3	179.8	84.5	81.2
Total	6543.8	6524.3	5004.8	4938.5

Source: Departamento de Estudos e Planeamento da Saúde, Direcção de Serviços e Análise, Direcção-Geral da Saúde

Multiple chronic pathology, polymedication, domestic and traffic accidents, mourning, internments in institutions, social isolation, the phenomena of abandonment, economic vulnerability, changes within the family structure and the inability to adapt to unaccustomed surroundings are some of the factors which occur with frequency among the elderly, conditioning their health, their autonomy, their independence and quality of life, making necessary an multidisciplinary assessment and integrated teamwork at local, regional and national levels.

Information on the more prevalent chronic diseases and the means to control them is fundamental to teaching the elderly how to deal with their development, prevention and complications. In fact, many diseases and accidents[17] are not fatal, but they can cause impairment and incapacity with psychological consequences that are not linked to age, but rather to frailty and insecurity and, therefore, loss of autonomy and independence.

Additionally, the organisation and functioning of the health services are not, in many cases, adapted to the present needs of older people resulting from the

17. In the EU, most of the accidents involving the elderly occur at home. (Cf. Paulo. Bugalho, Margarida. Pereira Miguel, José For Better Health in Europe, Report with the support of the European Commission, Lisbon. Instituto de Medicina Preventiva da Universidade de Lisboa, Portugal, 2001).

new demographic and social realities, often constituting barriers to the promotion or maintenance of their, and their families', quality of life.

Notwithstanding that the majority of the elderly are neither ill nor dependent upon others, account must be taken of the multiple requirements that derive from a specific multiple chronic pathological context, more common with age, resulting in the need for a coordinated and comprehensive model of continuity care which respects the principle of proximity applied to a rapidly ageing population[XXII].

It should be noted, however, that many of the factors that determine the health of the elderly and the impact on their families, fall outside the sphere of action of the specific health sector. Those factors are related to the safety and inadaptation of urban or rural environments and to social protection, housing[18], transports, education, formal and informal work, violence, negligence and physical, psychological, sexual or financial abuses[19]. The present Programme, therefore, is founded upon a multidisciplinary and multisectorial view of integrated performance, seeking to complement those actions developed by the various sectors which result in the improved health and well-being of the elderly.

While the elderly benefit from multiple initiatives and procedures from various sectors and at various levels of society, there does not yet exist a truly adhesive national, regional or local strategy which promotes, in an integrated perspective, the involvement of the various measures for active ageing during the lifespan.

Older people with increased risks, or who are in situations of transitory or fixed dependency, require special attention from the health and social services, in terms of organizing care control and global recovery through specially integrated responses adequate to their needs, responses that make imperative a revision of the paradigm of the healing approach of the health services and that of the more traditional social support forms of health care.

The present model of health care, often better organised to deal with acute episodic illness, is, therefore, inadequate to respond to the needs of an ageing population. Indeed, generating avoidable hospitalization, with consequent wasted resources, results in the emergence of dependency and even in the exhaustion of families whose resources and availability do not find any local or home support.

18. Approximately 11% of aggregates which include older people, in Portugal, do not have sanitary installations. (Cf. INE As Gerações Mais Idosas, Série de Estudos Nº 83, Portugal, Lisbon, 1999)

19. Abuse of the elderly "is a simple or repeated act, or absence of appropriate action in any relationship where there is the expectation of trust, that causes harm or anguish to an older person". (According to the International Network for the Prevention of Elder Abuse, Action on Elder Abuse, 1995)

These facts make compulsory the rapid application of an integrated conceptual model, consolidated in the integrated Continued Care National Network, by which it is proposed to promote the maintenance of the elderly in their own home and provide greater objectivity in their access to quality, flexible, transitory or long-term care, thus ensuring its continuity, that is to say, the promotion of the easy, on-going and unbroken transition of those in a situation of dependency between different types of response and levels of care services and social support, in order to add years of independence to their lives.

The more the model is founded on cooperation, through the establishment of partnerships that create synergies among the experience, competence and resources of different sectors of society, with respect for the ethical principles of transparency, responsibility and mutual understanding[xxiii], the greater will be its success.

In addition to taking its inspiration from the policy recommendations of international organisations, among which the Plan of Action for Ageing 2002[xxiv], and successful national experiments such as the Programme for Integrated Support for the Elderly (PAII[20]), the National Programme for the Health of the Elderly now being put forward also consulted the National Council for the Policy of the Third Age and has the scientific consensus of the Portuguese Geriatric and Gerontology Society (Section of the Lisbon Society of Medical Sciences).

I - PRESENTATION

In putting its strategies into operation, this Programme aims to contribute to the promotion of active and healthy ageing throughout the life-course and to create responses adequate to the needs of the elderly population. Its further objective is to encourage the active participation of older people in the improvement of their own health, autonomy and independence.

The stimulation of personal initiative in the elderly to encourage self-care is an ethical imperative; an acknowledgement of the humanistic concept on which a society is founded, of the State's responsibility and solidarity and of the awakening in each citizen of an awareness of belonging in the community through generous participation and endeavour in favour of the health of its frailest members.

20. Programme of Integrated Support for the Elderly. – PAII. Created by Joint Dispatch of the Minister of Health and the Minister for Employment and Social Security of 1.7.1994, D.R. nº 166, 11 Series of 20.7.1994

It is this basic principle on which the present National Programme is founded: to impart information relating to active ageing and those situations which most commonly affect the autonomy and independence of the elderly; to orientate, in the health sector, the organization of all those involved, whether professionals or users and to contribute to the promotion of autonomy- and independence-friendly environments, while mindful of the impact of these strategies on the main factors determining the active ageing process of each citizen.

The principles laid down by the United Nations in respect of the elderly[xxv] have also been observed: independence, participation, self-fulfilment and dignity, as have the principles that ageing is a lifelong process, that older people are a heterogeneous group and that individual diversity, which becomes more accentuated with age[xxvi], should be respected and its intimacy preserved.

The National Programme for the Health of the Elderly is based upon three fundamental principles:

- Promotion of active ageing as a lifelong process;
- Greater adaptation of health care to the specific needs of the elderly;
- The intersectorial promotion and development of environments which enhance the capacity for the autonomy and independence of the elderly;

The Programme also recommends that special attention be given to the frailest and most vulnerable among the aged[21]. Those situations considered of particular vulnerability are advanced age, sensorial alterations, malnutrition, the risk of falls, incontinence and polymedication. It also aims to contribute to the consolidation of strategic thought[xxvii] in the area of health policy capable of introducing changes and innovations in the health system at the various intervening levels; guiding action at a local level, including the areas of information, training and good practices; initiating synergies and intervention methods in other sectors similarly engaged in contributing to the health and well-being of this sector of the population and drawing from and enhancing existing national projects and programmes.

The purpose of the strategies presented, therefore, is to influence the adaptation of responses to the needs of older people, with vision that is capable of anticipating the new social realities emerging, rapidly and progressively, both in this country and in a European context.

21. Elderly "Frail " - Older people with a high risk of decompensation with the emergence of a new pathology. The frailty criteria were described by Winograd and are predictive of longer hospital stays, death, nursing home placement and loss of post-hospitalization functioning. They comprehend, namely at 65 and over, CVA, chronic or incapacitating disease, confusion, depression, dementia, mobility impairment, inability to carry out daily chores, falls within the previous three months, prolonged bed rest, sores, malnutrition, weight or appetite loss, polypharmacy, sight or hearing deficiencies, socioeconomic and family problems, use of restraints, incontinence and hospitalization not programmed within the previous three months. (Cf. Winograd, CH, Gerety, MB & col. Targeting the hospitalized elderly for geriatric consultation. J Am Geriatric Soc. 1983)

The Programme presents strategies and recommendations in areas of particular sensitivity which, directly or indirectly, contribute to the achievement of their general objective, constituting vectors for a consistent change but one also flexible and adjustable to the situation and evaluations diagnoses as they are made.

Within the scope of the current Programme, the Directorate–General of Health elects the Portuguese Society of Geriatrics and Gerontology as its permanent scientific intermediary, though other scientific societies, institutions and associations for elderly people may be called upon to give their contribution if necessary.

II – PROJECTED TIMESCALE

It is projected that the National Programme for the Health of the Elderly will be in force by 2010.

III - OBJECTIVE

The Programme aims to contribute to the generalisation and practice of the concept of active ageing in people over 65 years of age and to act upon those factors which determine loss of autonomy and independence, its main objective being:

- To gain years of independent living.[22]

IV – TARGET POPULATION

Resident population over 65 years of age.

22. Independence is commonly understood as the ability to perform functions related to daily living – i.e. the capacity of living independently in the community with no and/or little help from others. Daily living activities (DLAs) include, for example, bathing, eating, using the toilet, and walking across the room. The instrumental daily living activities (IDLAs) include activities such as shopping, housework and meal preparation (Cf WHO, Active Ageing, A Policy Framework. A contribution of the WHO to the Second United Nations World Assembly on Ageing, Madrid, Spain, April, 2002)

V – INTERVENTION STRATEGIES

The National Programme for the Health of the Elderly will be put into operation at regional and local levels by those services dependent upon Regional Administrations which will define Plans of Action, following the Programme's guidelines, with reference to regional and local diversity, promoting partnerships and taking maximum advantage of existing resources.

Particular importance is given to involving in the strategies of intervention directed at the health of the elderly, the media, teachers and other professional groups – especially those linked to safety and transport, local authorities and all social workers.

The present Programme establishes three major strategies of intervention in the areas of active ageing, the organisation and provision of health care and the promotion of autonomy – and independence-friendly environments, establishing recommendations for action that take into consideration age, gender, culture and the stimulation of the participation of older people in the system:

1) Promoting active ageing

Recommendations for action:

- informing and training the elderly on the following:

  a) moderate and regular physical exercise and the best ways to practise it;
  b) stimulation of the cognitive functions;
  c) controlling the sleep-vigil rhythm;
  d) nutrition, hydration, alimentation and elimination;
  e) maintaining active ageing, especially in the retirement phase.

2) Adapting care-giving to the needs of the elderly

Recommendations for action:

- to identify:

a) health determinants in the older population;

b) the most frequent difficulties facing the older population in gaining access to health care and services.

- to screen the frailty criteria[23], by means of the Periodic Health Exam (EPS);

- to inform the older population and their families on:

a) the correct use of the resources necessary to health ;

b) approaching the more common situations of dependency, namely motor, sensorial and cognitive, environmental and socio-family deficiencies:

c) coping with situations of mental deterioration, such as Alzheimer's disease, as well as the prevention of depression and pathological mourning;

d) coping with incontinence

e) the promotion and recovery of oral health;

f) the prevention of the adverse effects of self-medication and polymedication;

g) the provision of home care to sick or dependent elderly people;

- To give technical guidance to care providers on:

a) the types of, and adaptation to, technical aid;

b) approach to the most common disabling pathologies in the elderly: fractures, incontinence, sleep disturbance, disturbances linked to sexuality and memory, dementia, namely Alzheimer's disease, Parkinson's disease, hearing, sight, communication and speech problems;

c) improving access to information on medication;

23. Cf. page 13

d) adaptation of prescription medicine to elderly people;

e) the approach to the final phase of life;

f) the approach to mourning;

g) programming, organising, providing and evaluating home health care;

h) approach to the multidisciplinary and intersectorial health and independence of the elderly.

3) Promoting the development of self help environments

Recommendations for action:

- To inform the elderly on:

  a. The detection and elimination of architectural barriers, as well as the technologies and availability of services that enhance their safety and independence, such as the tele-alarm service;

  b. The prevention of domestic and leisure accidents;

  c. Safe use of public transports;

- To give technical guidance to care providers on:

  a. The prevention of domestic, recreational and transport accidents;

  b. The detection and appropriate channelling of cases of violence, abuse or negligence on older people.

VI – ACCOMPANIMENT AND EVALUATION

The Programme will be accompanied on a national scale by a commission to be appointed by the Director-General of Health. The regional accompaniment and evaluation will be undertaken by the Regional Health Administrations.

In order to permit the most accurate accompaniment of the programme and to measure differences discovered in its development, an initial assessment should be made based on indicators specifically defined for that purpose.

The global evaluation of the National Programme for the Health of the Elderly will be carried out at the end of 2009, without detriment to intercalary assessments.

The National Programme evaluation will be based upon the following indicators. Other indicators may be introduced at the intercalary assessments:

The proportion of elderly people that:

a) eat without or with little help from others

b) take a bath without or with little help from others

c) use the WC without or with little help from others

d) move around the house without or with little help from others

e) go shopping on their own or with little help from others

f) make their own meals or with little help from others

g) carry out regular housework on their own or with little help from others.

2. The proportion of elderly people that consider their health status to be good or very good.

3. Life expectancy without disability[24], per gender, at 65, 75, 80 and 85 years old

4. The percentage of people that benefit from integrated health care and social support in their homes

5. The proportion of elderly people hospitalised due to accidents

6. The proportion of elderly people hospitalised due to accidents with medication

7. The proportion of elderly people that live alone and independently

8. The proportion of elderly people that use the telephone, the tele-alarm or other technologies of communication, of security and support

9. The proportion of elderly people who keep social contacts, other than those that are linked to their daily routine.

24. Healthy life expectancy is commonly used as a synonym for "disability-free life expectancy". While life expectancy at birth remains an important measure of population ageing, how long people can expect to live without disabilities is especially important to an ageing population. The concepts of independence, quality of life and healthy life expectancy, were elaborated by attempts to measure the degree of difficulty an older person has in performing activities related to daily living (ADLs) and instrumental activities of daily living (IADLs), such as shopping, housework and meal preparation. (Cf WHO, Active Ageing, A Policy Framework. A contribution of the WHO to the Second United Nations World Assembly on Ageing, Madrid, Spain, April, 2002)

REFERENCES

I. OMS; Comunicado 19/99, de 6 de Abril
II. INE; *Estimativas da população residente. Portugal e NUTS III. 2001*. in Destaque do INE para a comunicação social, Portugal. 27 de Junho de 2002
III. INE; Ibidem
IV. Ministério da Saúde; Direcção-Geral da Saúde. A Saúde dos Portugueses, 1997
V. ONSA; MOCECOS-*Uma observação dos cidadãos idosos no princípio do século XXI*, Janeiro 2001
VI. Cf. Oservações ONSA, n°. 16. *Consumo de cuidados médicos pela população portuguesa segundo os dados obtidos pelos Inquéritos Nacionais de Saúde desde* 1987, 1995 e 1999; Junho 2002.
VII. WHO; *Ageing-exploding the myths. Ageing and Health programme (AHE)*. Geneva: 1999: 1-21; in WHO. Ageing and Life Course. Men, Ageing and Health. Acheiving health across the life span. Noncommunicable Diseases and Mental HealthCluster. Noncommunicable Diseases Prevention and Health Promotion Department. Ageing and Life Course Unit.WHOINMHINPH/01.2. Geneva.2001
VIII. WHO; Active Ageing. A Policy Framework. A Contribution ofthe WHO to the Second United Nations World Assembly on Ageing, Madrid, Spain, April 2002
IX. Ibidem
X. KALACHE, A.; Lunenfeld, B. WHO and International Society for the Study of the Ageing Male, in WHOINMHINPH/O 1.2. Geneva 2001
XI. EUROLINK AGE; Journal of Health Gain 1997, WHO 1995, US Department of Health and Human Services, 1990
XII. KALACHE, A.; Lunenfeld, B. WHO e International Society for the Study of the Ageing Male, in WHOINMHINPH/01.2. Geneva 2001
XIII. INE; INS, ONSA, *Esperanças de vida sem incapacidade física de longa duração*. Portugal Continental, 1995/1996
XIV. WHO; *Ageing and Life Course. Men. Ageing and Health. Acheiving health across the life span*. Noncommunicable Diseases and Mental Health Cluster. Noncommunicable Diseases Prevention and Health Promotion Department. Ageing and Life Course Unit.WHOINMHINPH/01.2. Geneva 2001
XV. WHO; *Active Ageing. A Policy Framework*, 2002
XVI. FERRINHO, P.; BUGALHO, M.; PEREIRA MIGUEL, J.; *For Better Health in Europe*. Report with the support of the European Commission. (Lisboa, Instituto de Medicina Preventiva da Faculdade de Medicina da Universidade de Lisboa. Portugal 2001)
XVII. Ibidem
XVIII. Ibidem

XIX. harrisonsonline.com. News; *Cardiovascular Disease Leads to Higher Risk of Dementia* (Pittsburgh, May 10, The Macgraw-Hill Companies, 2001- 2002)
XX. MINISTÉRIO DA SAÚDE; *Relatório de 2001 do Director-Geral e Alto Comissário da Saúde*; *Ganhos de Saúde em Portugal* (Lisboa, Direcção-Geral da Saúde 2002)
XXI. FERRINHO, P.; BUGALHO, M.; PEREIRA MIGUEL, J.; *For Better Health in Europe. Report with the support of the European Commission*. (Lisboa, Instituto de Medicina Preventiva da Faculdade de Medicina da Universidade de Lisboa. Portugal 2001)
XXII. WHO; *Ageing and Life Course. Men. Ageing and Health. Acheiving health across the life span*. Noncommunicable Diseases and Mental Health Cluster. Noncommunicable Diseases Prevention and Health Promotion Department. Ageing and Life Course Unit.WHOINMHINPH/01.2. Geneva 2001
XXIII. OMS; *Declaração de Jakarta*. Quarta Conferência Internacional sobre a Promoção da Saúde, 21-25 de Julho de 1997, Jakarta
XXIV. IIAssembleia Mundial sobre o Envelhecimento. *Plano Internacional de Acção para o Envelhecimento – 2002 documento provisório*. Madrid, 12 Abril 2002
XXV. Assembleia Geral das Nações Unidas de 16 de Dezembro de 1991. Resolução 46/91. Princípios das Nações Unidas a favor das Pessoas Idosas
XXVI. WHO; *Active Ageing. A Policy Framework. A Contribution of the WHO to the Second United Nations World Assembly on Ageing*, Madrid, Spain, April 2002
XXVII. Relatório Conjunto da Comissão e do Conselho da União Europeia. *Apoio das Estratégias Nacionais para o futuro dos cuidados de saúde e dos cuidados para as pessoas idosas*. Bruxelas, 20 de Fevereiro de 2003

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