

Primary Health Care and Aging: Edited Proceedings of the Consultative Group Meeting on Geriatric Training in Primary Health Care

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Abstract

From 21-25 February 2000, in San Jose, Costa Rica, a WHO Consultative Group was held on the topic of Primary Health Care for Older Persons, with representatives from 13 countries from around the world, as well as Headquarters and Regional offices of WHO and the private sector. In the policy statement that emerged from the meeting four basic principles were highlighted: universal accessibility and coverage on the basis of need, community and individual involvement, intersectoral action for health, and appropriate use of cost effective technologies in relation to the available resources. Three complementary integration functions are mentioned: **functional** with an integrated approach to the health needs of individuals over their life course taking precedence over episodic management of disease; **organizational**, with a focus on how health centers should function with interdisciplinary teams; and **educational** which addresses the knowledge and skills and attitudes needed by health professionals that will facilitate communication, networking, advocacy and mediation of resources. The proceedings go on to outline the objectives to be included in national plans on health of older people, as well as the extended benefits and outcomes to be expected from PHC strategies for older people. In promoting quality of care for older persons, positive and negative factors are mentioned, as are strategies to: stimulate interest in geriatric care, motivate general practitioners to focus on the care of elders, encourage teamwork among PHC staff, and encourage multi-sectoral collaboration in promoting the health of older persons. An example is provided of healthy ageing from Canada. The recommendations include defining and measuring an ageing friendly health center (with specific indicators for the latter), defining the role of the PHC team in promoting healthy ageing, characteristics that programs should have to promote “age friendly” services in the primary care setting, and outcome indicators for quality of care of elders at the PHC level.

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Introduction

From 21-25 February 2000, in San Jose, Costa Rica, a WHO Consultative Group was held on the topic of Primary Health Care for Older Persons. The Consultative Group consisted of representatives from Bahrain, Brazil, Canada, Chile, Costa Rica, Cuba, England, Ghana, India, Jamaica, Mexico, Spain, United States, and the US.-Europe-Middle East-Africa representative of March & Co. WHO was represented by its Headquarters as well as the Regional offices of Europe (EURO) and the Americas (PAHO/AMRO). The following statement and recommendations resulted from deliberations at a meeting.

I. Policy Statement on Primary Health Care for Older Persons

A. Rationale

The population shift demonstrated by increased numbers of older people is evident worldwide, and will accelerate during the next two decades. Population ageing is considered to be the most significant demographic trend, as worldwide we see tendencies towards low fertility and extended life expectancy.

Therefore, healthy ageing for all must be promoted throughout the world. This includes ensuring an adequate standard of living, preventing chronic, non-communicable diseases,

and the provision of appropriate health care. Since the concept of Primary Health Care (PHC) was defined and given international recognition in 1978, PHC has become a prime focus for the promotion of world health.

Four basic principles underlie the PHC approach:

1. Universal accessibility and coverage on the basis of need.
2. Community and individual involvement.
3. Intersectoral action for health.
4. Appropriate use of cost effective technologies in relation to the available resources.

To successfully meet the health challenges of present and future elders, PHC needs to build on its interdisciplinary strengths and move beyond the provision of fragmented, vertical health services, to provide comprehensive health care. This should be done through the development of PHC's role as a provider of integrated services in collaboration with the individual, the family and the community. This integrative role has three complementary dimensions: *functional, organisational and educational*.

Functional integration implies that the episodic management of disease should be superseded by an integrated approach to the health needs of individuals over their life course. Adopting a life course approach recognises the complex interactions between a series of critical transitions in life, which are marked by particular life events, health determinants and biological risks. The way these elements interact has implications for people's health, and the way in which they age. Over the entire life course, societal assets contributing to better health are: economic stability, social cohesion, the development and maintenance of coping skills, and opportunities for people to influence their environment. For many older persons the interplay of multiple disadvantages, individual choice and life circumstances have resulted in an increased likelihood of premature ageing with disabilities.

Organisational integration focuses on how health centres should function, both internally and in relation to other services. The concept of the multi- and interdisciplinary health team should be reinforced so that different PHC professionals engage in increased collaboration and not simply work under the same roof.

Integration with different agencies providing services for older people implies that PHC should clearly identify the limits of its mandate and work closely with clinical specialist services, social and welfare services and public health services to improve the quality of patient care.

Educational integration in PHC requires knowledge, skills and attitudes currently lacking in many training programs for health professionals. PHC professionals need to communicate, network, advocate and mediate between different community resources. PHC teams must be able to design and evaluate programs that are based on scientific evidence for the determinants of healthy ageing. Educational efforts must be focused on clarifying the concept of PHC, moving beyond the "medical model" of primary care.

B. Statement of Main Problems to be Addressed by Countries

The context of health care issues in old age includes atypical presentation of disease, multiple pathologies and the need for a multidisciplinary approach. The common geriatric syndromes include: falls, incontinence, immobility and confusion, i.e., the "geriatric giants". Additional training is required to cover the following conditions – depression, Parkinson's disease, thyroid disease, diabetes, malnutrition, pain management and problems due to medication.

Preventing iatrogenic diseases is also an important component of PHC interventions. Public health measures, which are systematically applied, will help to reduce iatrogenesis, which is created by health professionals in hospitals and long term care facilities.

C. Objectives to be Included in National Plans on Health of Older People

Commitments made through the endorsement of the resolutions on achieving Health for all, and the respective adopted regional policies, have enabled Member States to promote the health of older people and support the strengthening of the capacity of PHC services to respond to the health needs of the older population.

However, any commitments to the improvement of the health of older persons necessitate concrete actions on the determinants of health. A thorough understanding of the social and economic determinants of health should play a salient role in the development of PHC strategies. Income differentials, health choices and environmental protection are all amenable to public policy. Changes in these areas can lead to improved health and wellbeing for the entire population, including older people.

Developing an active plan aimed at reducing the negative image of ageing throughout the world must be priority. The development of flexible retirement policies and the availability of meaningful social roles beyond paid employment are necessary to improve the quality of life and well being of all older persons. Societies need to recognize and reward the significant contributions older people make for their families and society.

Public policy changes are necessary to enable an ageing friendly society. Active ageing can be achieved if public policies reflect the needs and views of older people, including housing, income and other measures that enhance people's autonomy and social productivity. The development, coordination, monitoring and evaluation of these services will help to promote active ageing and will recognise the interdependence of generations.

The promotion of healthy ageing requires health professionals to possess knowledge of geriatric care, in addition to strong analytical, communication and managerial skills. Specifically, these professionals need to be creative problem solvers, have team building

skills, and understand social and cultural realities.

Investing in the continuing education of PHC professionals in these areas and in the training of trainers should be a priority in the development of responsive PHC strategies for an ageing society.

D. Extended Benefits and Outcomes to be Expected from Strategies to Strengthen PHC for Older People

PHC strategies will support more coherent and comprehensive approaches to the care of older people, promote equitable distribution of health resources, and thus contribute to the production of health capital. Re-engineering health services towards PHC has the potential to have a positive impact upon both the cost and the efficiency of the provision of services to older people. Ultimately, this will have a positive effect upon the health status of older people, and thus contribute to an increase in quality of life.

Since the adoption of the PHC strategy in 1978, evidence suggests that Member States by and large have failed to coordinate activities and resources. Additional efforts must be made with regard to establishing priorities, and promoting quality assurance and operational research. Strengthening PHC for older people may enable service providers to recognise the trade-offs for social, economic and health development, considering the main demographic trends described above.

II. Promoting Quality of Care for Older Persons

The main factors that were determined to influence the provision of health care for elders were organised around the following sections: 1) Factors that influence old age care; 2) Strategies to stimulate interest in geriatric care; 3) Strategies to motivate General Practitioners to focus on the care of elders; 4) Strategies to encourage teamwork; and 5) Multi-sectoral approaches to promoting the health of older persons.

A. Factors That Influence Old Age

Care

Table 1 below lists many of the factors that influence old age.

Table 1
Factors That Influence Old Age

Context	Positive	Negative
Personal	<ul style="list-style-type: none"> • Positive experience with elders. • Self-confident competent elders who articulate needs, values & expectations. • Family and individual values. • Maturity of care provider 	<ul style="list-style-type: none"> • Negative experience of aging • Absence of models of healthy aging • Exposure mainly to frail elderly in training
Socio-cultural	<ul style="list-style-type: none"> • Positive societal attitudes to seniors • Community recognition of the value of care of elderly 	<ul style="list-style-type: none"> • Negative images of ageing • Community and family neglect of the elderly
Policy	<ul style="list-style-type: none"> • High policy priority on ageing • Sufficient resource allocation for care • Priority on lifelong health education • Appropriate incentives in remuneration policies and human resources planning • Appropriate system delivery structure (single entry point for services; comprehensive and integrated range of services) 	<ul style="list-style-type: none"> • Policy focus on other ages or issues • Insufficient resources for care • No life course perspective in health • Inappropriate or absent incentives for elder care in remuneration and human resource planning • Gaps and fragmentation in service delivery
Professional Practice	<ul style="list-style-type: none"> • Exposure to senior-friendly care setting and experience of successful interventions early in training • Adequate gerontology/geriatric content in curriculum • Presence of gerontology/geriatrics as recognised discipline in universities • Adequate evidence/base for effective intervention • Presence of opinion leaders in care of the elderly • Recognition of gerontology/ geriatrics as intellectually stimulating • Peer support and esteem for gerontology/geriatrics careers • Presence of reliable common assessment tools • presence of effective patient materials and community resources to support health interventions and education 	<ul style="list-style-type: none"> • Absence of gerontology/geriatrics in curriculum and among recognised disciplines or specialities • Lack of research evidence to guide intervention and, therefore lack of positive care outcomes • Perception of gerontology/ geriatrics as unrewarding and unstimulating • Lack of tools for assessment • Lack of resources to promote patient self-care • Exposure to frail elderly in poor conditions and with minimal chances to intervene successfully.

B. Strategies to Stimulate Interest in Geriatric Care

The following strategies should be Included in the clinical education of physicians and nurses:

- Provide opportunities to work with well elders.
- Show successful interventions in the treatment and care of elders.
- Place more emphasis on care, and show that it is not limited to women (“Real Men Care”)
- Provide achievable goals, targets and indicators for intervention in the care of older persons.
- Provide opportunity for continuity of care to show potential to achieve lasting impact.
- Model optimism in care of elders.
- Offer opportunities (e.g., traineeships) and incentives (e.g., continuing education credits, adequate reimbursement) for geriatric education.
- Within nursing, show that geriatric nurses often play a more important role than they do in other disciplines.

In summary, medical education must embrace a whole life course perspective.

C. Strategies to Motivate General Practitioners to Focus on the Care of Elders

- Improve geriatric undergraduate and post-graduate training and continuing medical education.
- Provide mandatory infusion of knowledge through re-certification.
- Enhance respect and leadership in Geriatrics through collaboration with geriatric specialists.
- Raise the academic profile of geriatric care in all medical studies.
- Involve general practitioners in decision-making and implementation of changes in practice guidelines, i.e., to share ownership and stimulate commitment.
- Create shifts within profession (medical association, colleagues).
- Provide role models among esteemed colleagues.

- Provide reliable, authoritative, easy-to-use information to help GPs solve clinical problems.
- Show that they have a special valued role.
- Ensure community resources: i.e., to support, complement, and reinforce medical interventions.
- Provide accreditation for primary care teams.
- Increase remuneration and status of care of the elderly, as it is often more complex.
- Provide professional guidelines to establish practice standards.
- Provide tools to guide quality management of chronic diseases
- Assess care practices (e.g., by peer review)
- Engage support of regional directors and other senior health managers.

D. Strategies to Encourage Teamwork Among PHC Staff

- Show the importance of allocating time to the process.
- Provide an appropriate physical environment.
- Convince physicians that triage of care works.
- Facilitate moving away from physician-led culture to team work by establishing roles of team members, delegation of duties and roles, empowerment, shared values and joint records.
- Provide feedback on team effectiveness.
- Increase the use of evidence-based best-practice approaches.
- Provide team learning.
- Involve the whole team in prevention activities (less disease oriented).
- Provide training in teamwork via opportunities to participate in actual teams, role identification, training in conflict resolution and in methods of collaboration.
- Show the benefits of the team approach.
- Change from a practice paradigm to a multidimensional model of care.
- Develop leadership capacity among all team members.
- Provide shared incentives (reward) and

accountability structures.

E. Strategies to Encourage Multi-Sectoral Collaboration in Promoting the Health of Older Persons

- Understand the determinants of clinical problems outside the clinic.
- Identify barriers and resources and build commitment to community problem solving.
- Encourage participation in community partnership and network building.
- Identify evidence from outcome research.
- Provide financial incentives for partnership in the private sector.
- Develop a multi-sectoral data base of indicators for health and aging.
- Engage the public in discussing multi-sectoral issues/implications.
- Conduct multi-sectoral demonstration projects and subsidise appropriate projects.
- Highlight media advertising with corporate goodwill associations.
- Encourage intergenerational collaboration.
- Develop volunteer programs with retirees.
- Reward innovative student projects involving multi-sectoral partners.
- Make it a pre-requisite of grants/funds that a multi-sectoral approach is visible.
- Advocate for / enact legislation that ensures health impact assessments and collaboration among sectors in attaining health goals.
- Decentralise power structures to the regional level where horizontal approaches can be adopted more readily

F. Discussion

The most important issues raised for consideration were the following:

- There is a focus on professionals and this leaves other members questioning if they are part of the team. It is important to consider how the patient and family members can be part of the team.
- Does the person who sees the patient first influence the team dynamics for the better or the worse?
- Teamwork must not be interpreted as

requiring that all patients need to be seen by all team members.

- The key questions for the team are: What is the goal of the intervention, and how does each member of the team meet this goal? What structure is needed to meet this goal? What factors are important in achieving the goal? Capacity, structure, knowledge and tools are the key components affecting the PHC team's ability to meet the needs of older people.

III. Health Promotion and Healthy Ageing

The main recommendations relating health promotion to healthy ageing included: defining and measuring an "ageing-friendly" health center, defining "healthy ageing", defining the role of the primary health care team in promoting healthy ageing, programs for the primary care setting, and outcome indicators for quality of care of elders at the primary health care level.

A. Defining and Measuring an Ageing Friendly Health Center

The value and efficiency of a health centre depends greatly on how accessible it is to the population it serves and on how the community perceives the quality of the services. Centres have created 'friendly' and 'enabling' environments for a target population in the past, such as "Children friendly" and "Mother friendly" Centres. The following summary reflects what the group considered to be the special characteristics of an "Ageing friendly health centre".

Ageing friendly health centres or programs would be:

- Based on a needs assessment including older persons and family caregivers.
- Accessible to the users, including transportation.
- "Friendly" environments for persons with hearing and vision loss and physical disabilities.
- Multi-service (outreach).
- Caring environments.

- Housed with competent staff trained in geriatrics.
- Health promotion-oriented (education classes).
- Culturally sensitive.
- Designed according to the approach of healthy cities and municipalities.
- Staffed by ageing-positive personnel.
- Integrated and with quality environments for all ages.
- Close to other services in the community.
- Supplied with education material and general information for elders (for example: on social security)
- Involving seniors as volunteers.
- Seeking user's opinions of services for ongoing change according to need.
- Accredited by WHO.
- Monitored and evaluated by "ageing friendly" indicators.

Indicators of an "ageing friendly" health centre:

- User satisfaction
- Clinical outcomes indicators (e.g. morbidity, functional status, length of hospitalisations.)
- Health care staff satisfaction with care of the aged.
- Recognition as training site (capacity to attract trainees).
- Track record of innovation and adoption of best practices.

B. Defining 'Healthy Ageing'

Healthy ageing is generally defined as the maintenance of functional capacity through physical, mental, social and spiritual well being over a life course to ensure a satisfactory quality of life in later years.

Healthy ageing includes:

- Capacity to adapt and respond to change through all transitions in life.
- Sense of continuity with one's history and identity.
- Adaptability to the needs of the ageing body
- Coping with changing nature of relationships.

- Desire to continue to learn, participate and be engaged with life.
- Positive attitude.

Healthy ageing means more than the absence of disease and disability and is the cumulative value of life long experiences, environments and life style.

C. Defining the Role of the Primary Health Care Team in Promoting Healthy Ageing

Health Promotion and Prevention:

- Health Education targeting the individual, the family and the community.
- Disease Prevention
- Health Maintenance

The intersection of health promotion, disease prevention and management is crucial to the understanding of Primary Health Care and includes:

- Assessment, management and monitoring of the resources and services needed by older persons
- Identification of specific stages; crucial life events; environments related to the health of the older client.
- Adequate links between the individual, the family and other resources available in the community.
- Follow-up on rehabilitative needs and resources for the frail elder.

In general the health care centre with the multidisciplinary team should:

- Identify community participation tools in accordance with the prevailing cultural, geographic, and social environments.
- Build multisectoral partnerships
- Collaborate with policy makers, researchers/ academic sector, administrative, and private sectors.
- Empower elders with information needed for self care.
- Facilitate, promote social and family support and community capacity.

D. Programs for the Primary Care Setting

- Engage everyone in creating age friendly centres, clinic or outpatient offices.
- Provide time and space for classes for elders and their families led by people from the community with appropriate expertise.
- Include elders/family/informal caregiver in decisions regarding care and services.
- Promote cultural sensitivity.
- Capitalize on the interest and time of older persons.
- Recognize that older men are harder to engage: develop gender specific programs/clinics

- Build education programs around common interests/hobbies. This is a carrot to get people to hear your health message.
- Provide screening which brings people in and builds awareness; e.g., free blood pressure check.
- Use conventional screening criteria, evidence-based guidelines.
- Critically evaluate the best way to establish clinical practice guidelines for the care of elders.
- Implement preventive guidelines.
- Program for outreach functions: use media (radio), churches, clubs, etc.

E. Outcome Indicators for Quality of Care of Elders at the Primary Health Care Level

Short-Term Indicators	Medium Term	Long-Term indicators
Attitude of elders towards the centre	Adherence of clients to PHC recommendations and treatments.	Changes in the healthy life expectancy and/or disability-free life expectancy of the community.
Degree of community participation, multi-sectoral cooperation.	Adherence of PHC team to practice guidelines.	Changes in inappropriate frequency and duration of hospitalization.
Frequency of identification of center as an “aging friendly center.”	Impact on service utilization.	Significant changes in individual’s life styles.
Degree of patient and family satisfaction.		

Health Promotion and Ageing: An Example from Canada

Building on the concepts and strategies of health promotion, Canada has broadened its policy framework to a population health promotion approach. Population health focuses on the entire range of factors, individual and collective, determining the health of population groups. Applying the approach to influence health outcomes requires an analysis of the social, economic, environmental, biological and behavioural factors that predict health risks and the collaboration of many partners from many different sectors to effectively address these factors over the life course.

The population health approach frames Canada’s actions to promote healthy ageing, which is understood as: The lifelong process of maximizing opportunities for economic, physical, social and mental well being.

The determinants of health are understood to have a differential, cumulative and interactive impact on the health of people as they age. Promoting healthy ageing occurs at the individual level and the society level.

At the individual level, interventions are designed to enhance:

- Resilience and adaptation.
- Personal autonomy and control, and
- Healthy behaviours.

At the societal level, interventions are directed towards developing:

- Healthy public policy
- Enabling and supportive environments
- Community capacity, and
- Appropriate and accessible health services.

Effective application of the population health approach to promote healthy ageing in a primary care setting implies that the primary care team considers all predictive health determinants; engages multiple players from multiple sectors and targets an appropriate range of individual and societal outcomes.

A. Healthy Ageing and Injury Prevention: An Example

Why address seniors' injuries?

- Seniors account for >25 of all hospitalisations due to injury in Canada.
- 33% of seniors in the community have at least 1 fall each year.
- 40% of seniors 80+ in institutions fall each year.
- Falls account for 40% of admissions to nursing homes and a 10% increase in home care services.

What are the determinants of injuries?

- Biological determinants: sensory loss, chronic illness, dementia, low bone density.
- Physical environment: environmental hazards, farms.
- Income: low income

- Gender: women
- Culture: aboriginal
- Health practices: inactivity, alcohol use, no assistive/safety aids
- Health services: drug reactions, restraints

Therefore, a health education strategy needs to be directed to different professionals in multiple sectors. The education program should target the following areas:

- Environmental design and building codes
- Home and product safety
- Assistive device and safety aid use
- Fitness, nutrition and safe medication use
- Prescription practices
- Alternatives to physical or chemical restraints

Based on a study of the population needs, Health Canada developed the following programs:

- The Safe Living Guide: A Guide to Home Safety for Seniors.
- How You Can Help Seniors Use Medication Safely
- Physical Activity Guide for Older Adults
- Communicating with Seniors: Advice, Techniques and Tips.
- STEPS project for community seniors and disabled persons empowered to identify and address injury risks.
- Injury control curriculum development program to train community-based-service-providers.
- Supporting self-care. Models and strategies to assist health professionals in promoting patient self-care practices.

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