



MOTIVATION

POSSIBLE RECOMMENDATIONS FOR AN INTER-AMERICAN GERONTOLOGIC PLAN

Population aging, as demographic situation, is an irreversible fact, at least until now.

In America, many countries have an aged population; the Nations that have not yet arrived at this situation in the coming years will be within this classification.

The Inter-American Conference on Social Security cannot be indifferent to this situation that is growing over time; which with no doubt has an impact on Social Security projects, in the short- medium- and long-terms.

Being aware of this, a few years ago the CISS created, by unanimity of its members, the American Commission for Older Adults—CADAM— a specialized technical body, with the purpose of doing research about this problematic. In consequence, it has the aim of analyzing and proposing possible solutions to a worrying subject in our nations.

The CADAM in its first studies gave some worrying data:

While it is estimated that total population of America between 1950 and 2050 will grow 5 times, those who are older than 60 years will grow 19 times in this period.


In addition, in 1950 the aged population represented 6.5% of total inhabitants; however, in 2050 it is estimated that they will represent 22.5% of total population.

If these actuarial calculations were done over time, the situation would be even more serious. For example, in 1950 the relation of young people aged 0-19 to people aged 60 or more was 9 to 1; nevertheless, in 2050 both groups will be of equal size.

With these demographic data, population aging is recognized as a fundamental variable for the desing of policies and programs in the countries towards the future. Therefore, we should from now on initiate actions that look for alternatives that help to bear these population and social changes.

Thus, the American Commission for Older Adults in cooperation with the General Secretariat of the CISS started working on the analysis of the countries' responses —countries with high rates of population aging— to their present problematics; as well as to identify the countries' programs towards a future of long-lived society.

After carrying out International Congresses and Seminars in diverse regions of the Continent, the Directive Board of CADAM concluded that it was necessary to elaborate an Inter-American Gerontologic Plan, which as the CISS recommended would be a useful tool for consultation



in the moment in which any country member had to solve subjects or to legislate on situations affecting the elderly.

CADAM has celebrated meetings in Argentina, Barbados, Chile, Costa Rica, Cuba and Mexico, in recent years. The subjects that motivate the Recommendations in an open and constructive way have been discussed in these meetings.

The recommendation-project presented in this XXIII General Assembly for its consideration is the result of more than 18 months of consultation among countries; in which the most famous experts of the Gerontologic science have participated.

It is precisely from this science, **Gerontology**, from which all the work is oriented, since it gathers in its analysis all factors that affect the risk-group we focus on.

At present, the psychophysical and functional state of an older person (or of someone who is near to become one) cannot be evaluated from a single specialty; instead, any action that lead to a correct diagnosis must be **Interdisciplinary**.

On the other hand, population aging requires a treatment that involves all society, without distinction of ages; therefore any program that is developed must consider **Intergenerational** support, and its implications.

Finally, it has been shown that individual efforts of any Social Security organization are insufficient; sometimes are also unfair as they can duplicate services and/or benefits—since several institutions usually work simultaneously for the elderly. For this reason, it is crucial that everything a State provides to the elderly comes from an **Interinstitutional** program; coordinated and controlled by all involved sectors.

The project that is presented for its consideration includes the Interdisciplinary, Interinstitutional, and Intergenerational actions as the right way to arrive at the Inter-American Gerontologic Plan.

The General Secretariat of the CISS, as well as the Directive Board of CADAM are aware that what we propose is only a base document of Recommendations that each member and each Nation can take into account, and adapt and improve to its specific needs. However, our only goal is to present this work as a tool of support and collaboration to membership at the moment decisions have to be made regarding the elderly.

Dear colleagues, with the humble satisfaction of the fulfilled work, the General Secretariat and the American Commission for Older Adults, presents for your consideration “***The Recommendations for an Inter-American Gerontologic Plan***”; which we hope will be satisfactory for all of you.

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RECOMMENDATIONS FOR AN INTER-AMERICAN GERONTOLOGIC PLAN

When the Inter-American Conference on Social Security presented its recommendations for an Inter-American Gerontologic Plan, it manifested that it considers fundamental to encourage an improved **intergenerational integration**, prioritizing the social role of Older Adults.

Viewing as essential that our countries should turn towards the establishment of **interdisciplinary policies** involving the State, Non-Governmental Organizations, Society, and the Family with a global and coordinated strategy, decreasing welfare practices and strengthening the path towards an adequate “Quality of Life” for every Older Adult.

These manifestations were based on multiple international antecedents which involve the most prestigious Agencies dedicated to the problematic of Nations facing the demographic transition, analyzing what occurs in societies when the Older Adults’ population increases, and what happens to an Older Adult person in those societies.

In this framework, the recommendations were oriented in a way to favor that the States, the

Organizations of the Community, the Families, and the Older Adults themselves articulate positive actions, support and stimulate a new **social integration** of persons over 60, thus reaffirming their effective and active participation.

Also, it was underlined as essential that the actions taken for and towards Older Adults have to be coordinated with efficiency and efficacy, effectiveness and equity¹, and that the joint **Inter-institutional, Interdisciplinary, and Intergenerational** effort should be the one tending to solve the problems that are typical of Older Adults, through a gerontologic plan aiming to guarantee an appropriate “Quality of Life”.

The recommendations were as follows:

1. Generate activities with participation from government and non-government institutions as well as with Older Adults themselves, in order to be capable of making decisions that involve the whole social group.
2. Encourage universal and complete gerontologic coverage, without exclusions or restrictions, making efforts in health promotion and protection.

¹ **Efficiency:** It is the optimal use of resources to obtain results at the lowest possible cost.

Efficacy: It is the extent to which the proposed goal is achieved, or the impact of an action.

Effectiveness: It is the result of the actions on the target population.

Equity: It is to offer each individual in the community what he needs to preserve his quality of life. It is not giving everyone the same thing.



3. Develop and carry out projects tending to offer a decent economic benefit for every Older Adult, either of a contributive or welfare origin, ensuring an income capable of satisfying their minimal needs. Economic allowances are considered a universal right, and not a sectorial obligation with established terms and resources.

4. Create the conditions so that public and private policies promote an integrated society where solidarity and mutual support among generations is encouraged.

5. Foster the Democratic and Plural organization of Older Adults.

6. Facilitate the development of research and planning on the subject, maintaining the executed gerontologic plan permanently updated; to this end, Agreements with National and International Organizations and Institutions may be entered into.

7. Promote the personal and intellectual development of Older Adults, encouraging training at every level and including the special programs at National Universities.

8. Prepare and execute training plans and programs for those who take care of Older Adults.

9. Permanently spread the developed gerontologic plan and promote the widest possible volunteer participation.

10. Prioritize programs directed to the most vulnerable Older Adult sectors, including special proposals for women in view of their higher life expectancy and their particular ageing.

11. Create awareness around the issues that affect Older Adults, beginning with the education of children.

12. Create awareness in the whole society of the circumstances of exclusion and inequity that daily affect Older Adults, as well as the solutions proposed for each case by the gerontologic plan that is being developed.

Comments

The fundamental axes of these recommendations are:

Foster intergenerational integration and solidarity.

Develop **policies which favor interdisciplinary actions.**

Tend to a new **social integration** between States, the Organizations of the Community, Families, and Older Adults themselves.

Guarantee **universality** of gerontologic **coverages**, including a decent economic allowance.

Foster **research and planification with gerontologic criteria.**

Search for personal and intellectual development through **Older Adults training.**

Train managers and care givers for Older Adults.

Publicize and create awareness of the problems and gerontologic issues starting with the education of children.

Prioritize the most **vulnerable** sectors of Older Adults affected by exclusion and inequity.

We are proposing to open the discussion to incorporate the following concepts to the recommendations completing the fundamental axes:



The Gerontologic Plan and the Programs and Projects in it included should focus towards

- Consider that in the approach of older adults' integral health the fundamental concept is not to “**cure**” but to “**take care**”, given that the idea of cure emphasizes the hegemony of medical knowledge and disease, with the added burden that the resources they use are limited because they depend on the technical scientific development. To take care shows the primacy of the communitarian issues, emphasizing health, and its great advantage is that the resources it uses pertain to the community.
- Develop actions with **preventive criteria from the health paradigm** point of view.
- Construct a **care system** that valorizes and respects the capabilities and preferences of Older Adults and the communities in which they live in.
- Sustain the **care system** in the **observation, characterization** of the population and its **segmentation in groups of homogeneous risk**.

Organize the care system on the basis of next criteria

- **Continuity.**
- **Integrity:** physic, psychic, social and functional care.
- **Progressiveness** in consonance with the concepts of **fragilization** as a inherent process to age and **fragility** as a multi-conditioned state.
- **Inter-disciplinarity** as a function of integrity.

- **Situational adaptation** of care according to the predominant **health, sickness, functional dependency** and/or **social vulnerability** condition because of the poverty or isolation in which Older Adults are into given that, although in reality situations do combine and there is the possibility to transit from one situation into the other, it is necessary to prioritize in order to define the most adequate strategies and rationalize the use of resources.



BASIC GERIATRICAL AND GERONTOLOGIC CONCEPTS TO DEFINE SYSTEMS OF CARE FOR OLDER ADULTS*

1. Basic concepts

Presentation of the problems in the elderly stage

The people who arrive at the called elderly stage, that within our contemporary societies is luckily already a majority, tend to face the following situations:

- Multiple medical problems.
- Presentation of the medical problems in atypical, not-specific and asymptomatic form, such as infections without fever, pneumonia without evident radiological manifestation, infarcts of myocardium or acute abdomen without pain, confused state as only presentation of many diseases.
- Masked depression.
- Sly evolution of dementia compensated for a long time by near relatives (mainly spouses).
- Recognition as “normal behaviors” of the aging and not as problems, on the part of the patient, its family, the caretakers and the professionals.
- Fast affectation of mobility and deterioration of the physical state and the mental health.

- Slow recoveries.
- Tendency to chronic conditions.
- Tendency to dependency.
- Easily passable limit between the therapeutic benefit and iatrogenic effects (to cause damage with the therapeutic measures).
- High incidence of psychic and social causes in the presentation and/or descompensation of medical problems.
- High risk of giving up of the informal caretakers although with persistence of the will to taken care on their part.

What is Healthful Aging?

The observation of the phenomenon of the prolongation of the life allows inferring that this circumstance occurs when the self-help capacity stays. We observe that the pathological aging is that occurs with functional dependency. Therefore we consider that a person is self-sustaining when he or she has the capacity to make decisions and to execute them, while a dependent person has necessity of partial or total aid to make decisions and to execute them in the daily life.

* It is appreciated the collaboration of the professional-technical team of AMAOTE.



Concept of frailty as a process and fragility as a state

Following the definitions of Swiss sociologist Lalive D'Epinay ⁽¹⁾, the fragility is a personal condition in which the next aspects are affected: physiological and neuro-sensorial of an individual implying loss of the reserves that allow to maintain the balance with the environment and/or to recover it after a negative event. These aspects are the following ones:

- **Sensorial:** fundamentally vision and hearing.
- **Neuromotor:** related to mobility.
- **Cognitive:** to know, to recognize, to remember, to think, to take care of, to calculate, to understand, to express.
- **Metabolic power:** related to an internal average balance of unstable and the next one to the limits between normal and the pathological thing.
- **Diseases:** that appears as an additional dimension of the process.

When two of these conditions are fulfilled we are before a fragile person; we can think that almost all the people begin a frailty process after 60 years of age. This explains why age is the main factor of risk, so that care must be continued and progressive for all the people. Even those which make an impression, or believe themselves to be healthy, must be controlled according to protocols, according to their conditions within the process. On the course of the process of frailty of the older adults enter the psycho-social and environmental aspects that form a fertile field in which progressively, the functional dependency, that is the great true problem of the older adults can prosper.

The psycho-social aspects that affect the fragility are circumstances which hardly are constituted only in old age but are rather formed throughout life. They are tied with personal history and the actions that the individuals make to favor surroundings, such as the absence of life-commitment (projects, participation), and the incapacity to recognize the problems and the necessities, and to be able to ask for and to obtain suitable aid. The socio-environmental aspects that affect the fragility are circumstances that define the context: the poverty, the absence of policies that recognize the problems of the sector, to define the necessities and to select the best strategies, the absence of infrastructure adapted to the necessities, the atmosphere conducive to pathologies, as well as the attitudes of hostility, indifference or abandonment.

2. Integral Geriatric Evaluation (IGE)

The Integral Geriatric Evaluation is a specific **technology to approach** the older adults, also denominated geriatric four-sided-evaluation, in relation to the variables that it considers. It is the departure point to establish a system of care. Its great value lies in that it allows the identification of the problems, to locate them in hierarchies of functional importance, to organize therapeutic and/or preventive strategies that improve the quality of life and optimize care in the short and long term. In geriatrics the integral evaluation takes the time necessary to evaluate the different aspects, investigating in first term those that seem affected more and are suggestive of a possible disability.



The IGE is applicable by different actors from the system if they act in a coordinated way and must define the configuration of clinical history of the geriatric physician or other professionals that must approach this population, for which they must have a suitable qualification. This technology of approach is composed by four components, intimately related and inseparable in the diagnosis: the treatment, the evolution, the rehabilitation and the maintenance.

First component of the integral geriatric evaluation: physical medical aspect

In this first component the personal and familiar antecedents study, the apparatuses, systems and organs, the combination of march/mobility/balance, the urinary incontinence, aspects of nutrition, dream and sexuality, the toxic and protective habits, the drug consumption, the symptoms, present signs, diseases, syndromes and their functional impact, the professionals involved in the attention and the changes recent or anticipated in a life of the old person.

It corresponds here to include the well-known geriatric principles know as "giants of geriatrics": syndrome of immobility and scars, acute confusion syndrome, syndrome of urinary incontinence and syndrome of instability and falls.

Second component of the integral geriatric evaluation: psycho-cognitive aspect

Cognitive aspects: Within these structures and functions are the next: memory, language, direction, recognition of objects and situations, and capacity to conduct actions. The mental pathologies whose effects are to be prevented or diminished are: dementia and depression.

Dementia has an incidence from 5 to 15% in persons older than 65 years of age, and of 20 to 50% in those older than 85 years. The continuous evaluation of this sphere is useful to diagnose this phenomenon and to clear fears with respect to forgetfulness that often are the result of distresses, anxiety, depression and insomnia.

In the affective aspects: The main disease is depression. Major depression has a prevalence of 1% in the old population, 27% of the non-institutionalized have depressive symptoms and this disease determines 37% of the reasons for consultation in primary attention. The effects of depression are: disability, deterioration of the quality of life, higher rate of successful suicides, high use of health resources, and to slow down or failure of rehabilitation. The problem worsens when the family and the professionals tend to associate these adverse events to questions related to age or economic situations, partners and relatives, losses or events that certainly must be considered risk factors and merit preventive practices but that not in all the individuals are the cause of depression.

In this field receive importance the life history, the emotional aspects, the moods, the stressing situations, negative personal and environmental events, such as losses of friends or of the spouse, loss of authority position, questioning on the own abilities, reconciliation with people who are important, adaptation to familiar mobility, resolution of the pain by the death of others and the proximity of the own one, maintenance of the sense of integrity reinforcing what has been, enjoyment of the experience, interest to leave a legacy, fear of deterioration



and dependency, and concerns about the way to die.

The psycho-social and environmental problems that act as negative stress factors shall be investigated exhaustively for the older adult and the familiar group, they can be related to:

- **The primary group of support:** deaths, familiar disease, disturbances as divorces, abandonment, separation, labor loss, change, abuse and violence, to be a “forced” care taker of a disabled.
- **Economic problems:** extreme poverty, insufficient own earnings, economic loss, insufficient economic support.
- **House:** loss of home, inadequate housing, unhealthy neighborhood, conflict with neighbors or proprietors.
- **Interaction with the legal system and crime:** judgments, being victim of criminal act, relation with criminal, arrest, imprisonment.
- **Social scope:** death, loss of friend or informer, to live single, to have to adapt to another culture, to be victim of discrimination, conflict with non-relative caretaker, the doctor or the social services.
- **Access to welfare services:** inadequate medical service, lack of transport, inadequate medical surveillance.
- **Other situations:** disasters, war, other hostilities.

Third component of the integral geriatric evaluation: social aspect

The variables that are approached are the social-familiar surroundings, the antecedents and habits of participation, the customs, the

cultural aspects, the habitat, the economic aspects, the recreational possibilities and the effective communitarian inclusion.

The Evaluation of the habitat includes the consideration of:

- Adjustment based on the security, functional autonomy, pathologies.
- Stability of the house (loss likelihood).

The economic surroundings refers to the capacity to face the necessities of the daily life including those originated ones by the occasional or chronic pathologies. **In the socio-familiar surroundings** the main caretaker identifies and evaluates the possibilities of complete or partial support. Considering that the familiar support has three components: economic, affective, instrumental. The modalities of the socio-familiar support system partner are the following ones:

- **informal:** not compensated, but provided by family, neighbors and friends;
- **formal:** paid directly or indirectly: public structures systems of social insurance, agencies of social welfare; and
- **semi-formal:** related to institutions like the churches, societies of support, centers of retired and other that include voluntary work.

Fourth component of the integral geriatric evaluation: functional aspect

This is the most evident manifestation of the integrity of the other analyzed variants. The functional autonomy is manifested in: capacity of **self-care** in **Fundamental Activities of Daily Life (FADL)**, capacity of **autonomy** in



Instrumental Activities of Daily Life (IADL), and capacity of social *participation* in Advanced Activities of Daily Life (AADL).

Capacity of social participation in advanced activities of the daily life (AADL): These activities are the first that are lost with the deterioration and among them they are: the interpersonal relations with family, friends, acquaintances (to visit, to be visited), intergenerational relations, to study, to teach, to know and to use new technologies, to make recreational, productive, artistic, artisan activity, sports, activities physical activities of political representation, defense of rights, exercise of citizenship (it is possible to consider that a person capable to integrate himself or herself to an organization, to represent others and to be represented in the exercise and defense of his rights, has a superior category of citizen), shared activities, activities related to the spirituality and the religiosity.

Self-care capacity in fundamental activities of the daily life (FADL): It is estimated that the deterioration in at least 2 of these activities reduces in half the life expectancy with respect to a person of the same age that conserves all the functions. These are: feeding, displacement from bed to armchair and within the house, urinary incontinence, use of toilets, dress and personal hygiene.

Capacity of autonomy in instrumental activities of daily life (IADL): They are those that allow the relation of the individual with the community

and his or her power of performance: use of the telephone, use of transports, food purchases and preparation, to taken care and do the house, medication handling, independence in economic subjects, capacity to make applications and follow proceedings.

In a figured sense it is said that the functional dependency is a return way that begins downtown and finishes in bed. The evaluation of the functional capacity in FADL and IADL allows to track risk factors, to define the basal situation, to monitor the evolution and to define what type and with what periodicity, an older adult needs aid to remain at home without risk or need of being institutionalized.

3. Characteristics of the system of care for advanced age people

From the foregoing discussion, it can be said that in a balanced system, care must be:

- Continuous.
- Integral: physical, psychic, functional and social.
- Progressive: according to the course of the frailty process
- Interdisciplinary.
- Situational: by predominance since always the coexistence of situations can be given, but at every moment there will be one of high-priority, which does not exempt to those who must manage to plan for all circumstances (health condition, disease, functional dependency, vulnerability by poverty or isolation).



- The necessities in the HEALTH situation are the promotion and the protection of health and the prevention of bio-psycho-social pathologies.
- The necessities for the DISEASE situation-problem are the early diagnostic, and the opportune treatment and rehabilitation.
- The necessities for the DEPENDENCY situation-problem are the domiciliary attention, the daytime attention (day home, center by day, hospital by day with functional variations of social and/or sanitary character), the formation and care of caretakers and the definitive institutionalization. None of these is alternative of the others if the inclusion criteria are well defined and applied.
- The necessities for the VULNERABILITY BY POVERTY OR ISOLATION situation-problem are to facilitate the access to treatments, nutrition, safe and functional habitat, and to create participation instances.

4. Contributions to a national geriatric plan in the meeting of the CADAM in Cuba

The CADAM held a technical meeting in Havana, Cuba (September 1 – 3, 2005). There it was discussed that based on the analysis and situational diagnosis that takes place applying the technology of Integral Geriatric Evaluation it is possible to develop the “axes of a model of social-sanitary management centered in the older adult”.

In order to assume the promotion of health, prevention, treatment and rehabilitation of the disease of the older adult, it is necessary to recognize that the criteria that define the health-disease situation of the beneficiary population

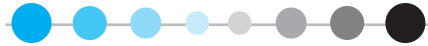
involve physical, psycho-cognitive, functional and social aspects. It is essential to know and to follow all the population of older adults, segmenting it into groups of homogenous risk which will allow to identify and to quantify the more problematic, to determine the needs and to select the actions that define the basic service guidelines whose axes are:

- Apply national social-sanitary guidelines.
- Adhere to the strategy of Primary Attention of Health with geriatric and gerontologic profile.
- Apply systematically the strategy of Integral Geriatric Evaluation.
- Manage the physical, psycho-cognitive, functional and social aspects.
- Articulate the socio-sanitary risk levels with the complexity of the intervention in primary, secondary and tertiary prevention.
- Maintain and fortify the continuous links with the sense of belonging, be it at home or in institution (acute or chronic).
- Manage through social-sanitary interdisciplinary teams close to the older adult in all the instances of his or her daily life and with a proactive criterion.
- Act in an inter-institutional network.
- Evaluate the actions systematically.

It is useful to remember here the **Principles of Primary Attention in Geriatrics**.

Also for this the age group the most suitable strategy is the Primary Attention of Health, which must fulfill the postulates adapted to the older adults:

- **Accessibility:** to consultation, domiciliary attention, and suitable telephone access.



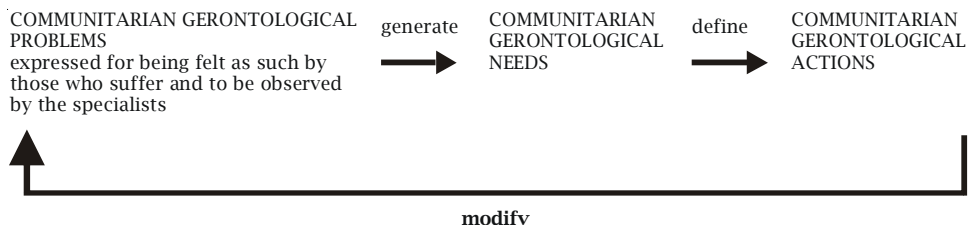
- **Integrated support:** to confront physical, social, sexual, psychological, fiscal, ethical problems.
- **Coordination:** of the health team.
- **Continuity:** to guarantee the mechanisms of reference between the different effectors from the network.
- **Responsibility:** of the team in the monitoring and fulfillment even of those older adults not willing to cooperate or demand support.
- **Clinical alert:** mainly of the variations in the mental and functional state.
- **Anticipation:** to the problems.
- **Defense of the old patient.**
- **Integration of the role of the family and the caretakers.**
- **Functional emphasis with views to prevent the disability.**
- **Exact diagnosis:** do not consider age as the cause of all evils, neither as criterion for the exclusion of certain modern technologies and its risks and benefits.
- **Serial observation:** sustained in the principle “to hope and to see”.
- **Active intervention:** clarification of the desired effects.
- **Correct monitoring.**


- **Dedicate sufficient time:** for the diagnosis and the monitoring.
- **Postponement of dependency.**
- **Communication:** with the patient, the family, all members of the team and between the different levels.

5. System of approach based on the situational reality of the older adults

The application of the gerontological strategies described is fitted within an approach methodology that includes the three inter-related fundamental components of the planning of a system of socio-sanitary attention for older adults are defined.

In this model, health is conceptualized from an *ecological* point of view, putting the accent in describing the atmospheres in which the life of an individual passes, to include/understand them operationally. This way it is possible to see the subject of the prevention and the microsocial context in which he or she moves. The use of these concepts allows us to contextualize the individual answers and to describe the situations in which life passes. Considering it, the work in the community is emphasized to include/understand how the different problems related to health and





prevention and the representations that arise around the actions of the subject. With these representations released, we can *draw* what the Dr. Ana Lia Kornblit ⁽²⁾ denominates **cognitive maps**. The design of these maps allows elaborating special strategies of intervention in support of health and specially of prevention through the main role of the social groups to which they directly go; otherwise, these strategies could be coherent with the ideology of the work teams but ineffective to fulfill the stated objectives.

Another important question to consider is the contributions of the *theory of social learning* that stresses the importance of the learned habits the execution of conducts.

The gerontological problem

The definition of the **problem** arises from the combination between the subjective perception and taking of conscience of those who are affected, and the objective observation of the reality on the part of those who have theoretical-practical knowledge and wish to take part on the solution. The problem will be translated in real demand only if whoever is affected feels it, suffers it as a difficulty to reach a goal that in this case would be to have a suitable quality of life, and in addition he or she decides to act through himself or herself or others to modify the circumstances in such a way that the problem is overcome.

Someone affected by a problem cannot always perceive it. It can happen that he or she relates the suffering to circumstances that are not the true cause of the problem or that, still making a

suitable recognition, because of adverse circumstances, from fear, disbelief or lack of will, he or she does not decide to ask for support. This would constitute the concept of *hidden demand*, that should not exist if a proactive system were able to detect it, but that often prevails for reasons fundamentally of economic inequity.

Anyway the system that has the responsibility to offer suitable care must recognize the problem to act, that is to say, must identify it even when the demand on the affected part remains muted.

The risk groups

The observation of the problems of the older adults allows characterizing them through risk groups. The variables that are considered are fundamentally three:

- a) The **functional autonomy** for the basic and instrumental activities of daily life tied to physical, cognitive and psychic health;
- b) The **socio-familiar environment** with its components: instrumental, affective, economic, habitat and the communitarian support; and,
- c) The **pathological status**, that can be compensated (cared for) or not.

Let us remember that in geriatrics, it is exceptional to find a situation in which disease diagnostic do not exist, since this is one of the five dimensions that define the frailty process.

The gerontological need

The definition of **need** arises from the understanding of the problem and in this



determination can influence variables of diverse nature: cultural, political, ideological, economic, social and affective. Someone who suffers a problem can or cannot identify the necessary resources suitable to modify the circumstances that originate it; the party who has the responsibility to coordinate the means to provide a solution to the problem must determine the needs accurately and this determination must be agreed between the different actors.

In relation to the gerontological problem and based on the socio-sanitary system that allows to approach it suitably, we observe that their fundamental variables allow to certify nine

groups of risk in which the population can be segmented, each one including a sub-group based on the state of the pathology that presents/displays. To each one relates a package of benefits and needs.

The gerontological action and the actors:

Based on the identification of the problems, the characterization of the population in risk groups and the determination of the benefits and needs, we can define actions and who must carry them out, always within the framework of the organized community, and while possible, in the familiar context.

RISK GROUP	SUB-GROUP PROBLEM (situation of the older adult)	NEED	ACTION-ACTORS
I* Autonomy Socio-familiar containment suitable	Without pathology or compensated pathology	Protocolized controls in health or of the compensated disease, preventive activities and of socio-sanitary promotion.	Ambulatory attention, clinical doctors, specialists, mental health, complementary studies of first level, interdisciplinary infirmary, dental care, equipment for prevention and promotion, sanitary agents for monitoring and alert.
	Unattended pathology	Attention of the unattended pathology and rehabilitation.	Clinical doctors, specialists, mental health and complementary studies of first, second and third level of attention ambulatory and domiciliary infirmary, internment in second level, service of emergencies, rehabilitation, agents for monitoring to the discharge.

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RISK GROUP	SUB-GROUP PROBLEM (situation of the older adult)	NEED	ACTION-ACTORS
2 [*] Autonomy Socio-familial containment insufficient or inadequate	Without pathology or compensated pathology	Protocolized controls in health or of compensated disease, preventive activities and of participation promotion containment, economic aid for medicines, housing cover or basic unsatisfied needs, nourishing reinforcement.	Ambulatory attention, clinical doctors, specialists, mental health complementary studies of first and second level, ambulatory attention, infirmary, dental care, social work and interdisciplinary team for prevention and promotion, evaluation and sanitary allocation of economic, housing, nutritional aids, agents, possible day home.
	Unattended pathology	Protocolized attention of the unattended pathology, rehabilitation, domiciliary attention, economic aid for medicine provision, therapeutic nourishing reinforcement, reinforcement of the networks of containment based on the pathology.	Clinical doctors, specialists, mental health and complementary studies of first, second and third level, ambulatory and domiciliary infirmary, sanitary internment in second level, emergencies, agents for monitoring to the discharge of second level, day centers, rehabilitation, transitory domiciliary attention, social work and interdisciplinary team for evaluations and allocation of economic, housing or nutritional aids.
3 [*] Autonomy	Without pathology or compensated pathology	Protocolized controls of the compensated disease, preventive activities and of promotion, participation, containment economic help for medicines, housing or basic unsatisfied needs, nourishing, mess service, meal packages.	Ambulatory attention, medical, clinical, specialists, mental health and complementary studies of first and second level, infirmary, dental care, social work and interdisciplinary team for prevention and promotion, evaluations and sanitary allocation of economic, housing or nutritional aids, agents, day home.



(continued)

RISK GROUP	SUB-GROUP PROBLEM (situation of the older adult)	NEED	ACTION-ACTORS
Without socio-familiar containment	With unattended pathology.	Attention of the unattended pathology, rehabilitation, domiciliary attention, economic aid for medicine provision therapeutic nourishing reinforcement, domiciliary handbag or meal package, reinforcement of the networks of containment based on the pathology.	Clinical doctors, specialists, mental health and complementary studies of first, second and third level, ambulatory and domiciliary infirmary, sanitary internment in second level, emergencies, agents for monitoring to the discharge of second level, day centers, rehabilitation, transitory domiciliary attention, social work and interdisciplinary team for evaluations and allocation of economic, housing or nutritional aids.
4* Semi-autonomous (aid for IADL)	Compensated pathology (from this risk group on, the possibility of nonexistent pathology is excluded)	Protocolized controls of the compensated disease, preventive activities and of promotion socio-sanitary, systems of diurnal attention, special system of alert and monitoring, possible professional monitoring of the familiar group.	Clinical doctors, specialists, mental health and complementary studies of first and second level, ambulatory and domiciliary attention, infirmary, interdisciplinary team of domiciliary attention, dental care, equipment for prevention and promotion, sanitary agents.
With suitable socio-familiar containment	Unattended pathology	Attention of the unattended pathology, rehabilitation, taken care of the caretaker, professional containment based on the pathology.	Clinical doctors, specialists, mental health and complementary studies of first, second and third level of attention, ambulatory and domiciliary infirmary, sanitary internment in second level, service of emergencies, rehabilitation, agents for monitoring to the discharge of second level, familiar support.

(continued)

RISK GROUP	SUB-GROUP PROBLEM (situation of the older adult)	NEED	ACTION-ACTORS
5 ⁺ Semi-autonomous	Compensated pathology	Controls of the compensated disease, preventive activities and of promotion socio-sanitary, support for IADL, diurnal attention, taken care of the caretaker, economic aid for medicine provision, housing cover or basic unsatisfied needs nourishing reinforcement domiciliary type meal package, inclusion in networks, special system of alert and monitoring, possible professional monitoring.	Clinical doctors, specialists, mental health and complementary studies of first and second level, ambulatory attention, infirmary, dental care, equipment of domiciliary attention, social work and interdisciplinary team for prevention and promotion, evaluations and sanitary allocation of economic, housing or nutritional aids, agents.
Socio-familiar Containment insufficient	Unattended pathology	Attention of the unattended pathology, rehabilitation, domiciliary attention, aid for medicines, nourishing reinforcement, therapeutic domiciliary type meal package, taken care of the caretaker, inclusion in networks, professional containment based on the pathology.	Clinical doctors, specialists, mental health and complementary studies of first, sanitary second and third level, attention ambulatory and domiciliary infirmary, internment in second level, service of emergencies, agents for monitoring to the discharge of second level, day centers, rehabilitation, domiciliary attention, social work and interdisciplinary team for evaluations and allocation of housing or nutritional economic aids.



(continued)

RISK GROUP	SUB-GROUP PROBLEM (situation of the older adult)	NEED	ACTION-ACTORS
6* Semi-autonomous	Compensated pathology	Protocolized controls of the compensated disease, preventive activities and socio-sanitary promotion, support for IADL, diurnal attention, economic aid for medicine provision, cover for housing or basic unsatisfied needs, nourishing reinforcement, domiciliary type meal package, inclusion in networks, containment, and possible internment in residence for older adults.	Clinical doctors, specialists, mental health and complementary studies of first level, domiciliary support, infirmary, dental care, social work and interdisciplinary team for prevention and promotion, evaluations and allocation of economic or nutritional aids, sanitary agents, center by day, call to account older adults.
Socio-familial containment nonexistent	Unattended pathology	Attention of the unattended pathology, rehabilitation, domiciliary attention, economic aid for medicine provision, therapeutic nourishing reinforcement, domiciliary handbag or meal package, inclusion in networks, professional containment based on the pathology.	Domiciliary attention, medical clinical, specialists, mental health and complementary studies of first, second and third level, domiciliary infirmary attention, internment in second level, emergencies, agents for monitoring to the discharge of second level, day centers, rehabilitation, transitory domiciliary attention, social work and interdisciplinary team for evaluations and allocation of economic or nutritional aids.
7 Employee (it requires aid for the basic activities of the daily living)	Compensated pathology	Protocolized controls of the compensated disease, diurnal attention, professional containment, taking care of the caretaker.	Clinical doctors, specialists, mental health and complementary studies of first and second level, infirmary, domiciliary support, sanitary dental care, center by day, agents, Interdisciplinary professional team.

(continued)

RISK GROUP	SUB-GROUP PROBLEM (situation of the older adult)	NEED	ACTION-ACTORS
Socio-familiar containment suitable	Unattended pathology	Attention of the unattended pathology, rehabilitation, taking care of the caretaker, professional containment based on the pathology.	Clinicians, specialists, mental health and complementary first, second and third level, sanitary domiciliary attention and support, internment in second level, emergency service, rehabilitation, agents for monitoring to the discharge of second level.
8' Employee	Compensated pathology	Attention of the compensated disease, support for FADL and IADL, diurnal attention, taking care of the caretaker, economic aid for medicine provision, cover for housing and basic unsatisfied needs, nourishing reinforcement, domiciliary meal package, inclusion in networks, containment, possible internment in residence for older adults	Medical clinical domiciliary attention, specialists, mental health and complementary studies of first and second level, sanitary attention, infirmary, dental care, social work and interdisciplinary team for prevention and promotion, evaluations and sanitary allocation of economic or nutritional aids, domiciliary support, day center, possible residence for older adults.
Socio-familiar containment insufficient	Pathology Unattended	Attention of the unattended pathology, rehabilitation, support for FADL and IADL, diurnal attention, taking care of the caretaker, economic aid for medicine provision, cover for housing and basic unsatisfied needs, nourishing reinforcement, domiciliary meal package, inclusion in networks, containment, possible internment in	Medical clinical domiciliary attention, specialists, mental health and complementary studies of first and second level, sanitary attention, domiciliary infirmary, internment in second level, emergency service, agents for monitoring to the discharge of second level, rehabilitation, social work and interdisciplinary team for evaluation and allocation of housing or nutritional economic aids.



(continued)

RISK GROUP	SUB-GROUP PROBLEM (situation of the older adult)	NEED	ACTION-ACTORS
9'	Compensated pathology	Protocolized attention of the disease, compensation, containment, internment in residence for older adult's common or specialized disease.	Clinical doctors, specialists, mental health and complementary studies of first and second level, domiciliary attention, infirmary, dental care, social work and interdisciplinary team, evaluations and sanitary allocation of economic or nutritional aids, sanitary agents, internment in common or specialized residence for older adults.
Employee Socio-familiar containment nonexistent	Unattended pathology	Attention of the unattended disease, rehabilitation, professional containment based on the pathology, specialized residence for older adults.	Sanitary domiciliary attention, specialists mental health and complementary first, second third level studies, domiciliary infirmary attention, internment in second level, emergency service, sanitary agents for monitoring the discharge of second level, rehabilitation.

System of care in the long term - boarding criteria

The analysis of the socio-familiar surroundings takes us to define the period during which the older adult does not count on effective aid in quality or amount. That varies between a minimum and a maximum:

- **Minimum:** up to 2 hours per day, never in the night.
- **Day interval:** more than 2 hours per day, never in the night.
- **Night interval:** during the night and not more than 2 hours in the day.

- **Maximum:** during the night and more than 8 hours in the day.

The evaluation of functional autonomy takes us to define the intervals free of aid, that is to say, the time that the person can be without aid, without running risks of life or complications in his or her functionality.

Long interval free of aid: need of assistance at least once a day (2 or 3 times a week or less), persons who can move around at home and perform light domestic tasks, have difficulties

to purchases groceries, to do proceedings or use transports. They require sporadic presence of people who offer them aid: to accompany them for example to receive recreational, cultural, religious services or retirement benefits, attend some consultation or medical practice, perform heavy hygiene of the house and do important purchases.

Short interval free of moderate aid: attendance once a day, never at night; persons who mobilize themselves in the house, cannot prepare food, do not go out, can take medication but not prepare it.

Short interval free of intensive aid: help several times a day at stated times: for the transference bed-armchair, medication administration, to approach them prepared food.

Interval free of critical aid: aid at intervals very brief or never can be alone.

The cross-correlation of the variables that define functional autonomy and those that correspond to the socio-familiar continece allows the determination of the type of aid that a dependant older adult requires. This approach facilitates the modulated allocation of care according to type, frequency and duration, according to the following scheme:

6. Prevention is the fundamental strategy

The communitarian vision that allowed the development of the strategy of Primary Attention of Health stresses the change of paradigm to approach the objectives of well-being of the people in health terms. We have seen how the axis oriented to the **support to disease** was very advisable in economic terms for some groups but it finished being an almost unbearable and interminable load in terms of expenses and to allocation of public resources, to which private providers transfer the load when disease becomes very expensive.

		Potential needs of aid		
		Little	←————→	Considerable
		INTERVAL FREE OF AID		
		Long	Short	Critical
Effective Possession of aid ↑ Sufficient ↓ Little or none	Minimum	Does not need additional aid		Home aid
	Day	Only	Home aid	Home aid Day center
	Night	Occasionally		
	Maximum	Home aid	Home aid Residency for older adults	Residency for older adults
Periods without effective aid in quality or amount				



Today we observe that, suitably, the **support** to the **situation of dependency** is recognized as a right of the people; glimpsing also the possibility of “good business.” Yet, there appear difficulties of organization and provision of resources, as well as problems in relation to the inclusion criteria, permanence and exit of the system.

*Our efforts are oriented towards **Prevention as investment.***

Some of the concepts exposed above talk about the welfare needs of persons who today would be in situation of functional dependency but it is essential to approach the topics referred to in **the preventive area** that it is the only strategy that will prevent that population aging does not become a paradoxical “**failure of the success**”, where overwhelmed societies must dedicate more and more resources to the attention of chronic pathologies and disabilities. It happens also that some young people forced to take care of an elderly, are also aging without being able to enjoy life because of their responsibilities as caretakers, and end up wishing unconsciously and act thinking about reverting the situation, limiting their capacity to continue living.

These preventive strategies, although it is correct to think that they must begin with the beginning of the life, will begin to be applied rigorously and systematically by the fourth

decade of age, when the conditioners of the process that will happen in the old state seem to begin to constitute and organize themselves.

In addition, the “never too late” spirit is absolutely effective. Today we can consider that it is possible to incorporate the criterion of “gain of capacities in the elderly stage” because with suitable stimulation it is observed that the people have gains that never before were obtained, in addition to recover some of what was believed lost.

A general program of prevention with a gerontologic profile must basically approach the following aspects tied to the promotion and the protection of health and environment, nutrition, physical, psychic and cognitive stimulation, legal aspects, abuse and mistreat, education, habitat, integration and social participation.

Orientation concepts in prevention

How to explain the causes of senile deterioration and the prevalence of non-medical factors in the ways of becoming ill and of dying? The “rule of the thirds” is an illustrative and optimistic concept because it shows that is possible to act preventively or therapeutically on two thirds of the deterioration causes. Similarly, the following figures provide statistical data that demonstrate the value of the preventive actions on the atmosphere and lifestyles. As a whole, these data help to construct a map for action in the field.

1/3 of the problem	1/3 of the problem	1/3 of the problem
Bad use, disuse or abuse of bodily structures and functions	Diseases	Physiological aging, related to genetics



Relative weight of the factors that take part in illness and mortality by pathologies

Causes of death	Medical systems	Lifestyles	Environment	Human Biology
Cardiac	12%	54%	6%	28%
Cancer	10%	37%	24%	29%
Brain-vascular	7%	50%	22%	21%
Accidents	13%	70%	16%	1%

Relative weight of the health-disease-death state conditioning factors

Biology, inheritance	Environment	Life styles	Medical system
27%	19%	43%	11%

Indicators of high risk in older adults:

- Nocturnal complete or partial solitude or during many hours in the day.
- Low score in functional autonomy
- 80 years and more
- Unmarried, in particular single woman or widow
- Socially isolated
- Old without children
- One in the couple is disabled
- Inadequate habitat based on: autonomy, pathology, conditions for rehabilitation
- 90 days after leaving the hospital
- Lack of contact with attending physician
- Other household members of visitors not qualified or too busy to provide care
- Inadequate economic context
- To live alone at home
- Lives in an institution not properly regulated
- Old without children
- Old person in charge of the care of others
- Chronic and/or disabling pathology
- Undernourishment
- Multiple medication or medication of high risk
- Complex treatments

7. Proposals for action

As indicated in the Americas Social Security Report 2006, published by the CISS, there is an important lag in the region in the development of long term care programs for the older adult. For that reason, the recommendations of the CADAM must be seen with urgency, and the countries, the institutions,

the communities and still the families must each one think about the best form to put into action the ideas.

A set of specific proposals for the action is the following one:

- Program of communitarian qualification in elderly stage.



- Reevaluation and gerontologic monitoring of vulnerable groups in the community.
- Communitarian gerontologic research.
- Establishment of a preventive program with communitarian base.
- Design and implementation of a non-pharmaceutical drug list, mandatory coverage of preventive actions complementary of medical treatments for the prevalent pathologies in the elderly stage.
- Communitarian, local and regional research.
- Actions on the habitat.

Also it is advisable to launch a program of communitarian training on the elderly stage that allows finding solutions to all the layers of society, to all the professionals and technicians who deal with the older adult, to the families and the older adult himself or herself. The target populations are the older adults themselves, the leaders and the sanitary personnel of NGOs that represent the elderly stage, the health sector agents, the members of focused communities (native inhabitants, religious communities, others), aspiring and functioning domiciliary caretakers, the professionals of stimulation of movement, the families that include older adults with pathologies by e.g. Alzheimer disease, the administrative and welfare personnel of establishments that take care of older adults, the young students of secondary schools interested in the subject, the administrative personnel of institutions who take care of adults greater, the institutions of

security and civil defense, the personnel of public transport and road security, the non-specialized personnel of municipalities, professionals through the professional councils and in universities, persons in charge of buildings of departments, the beneficiaries of social plans, and the employees of commerce and banking that take care of the older adult.

8. Conclusions

The analysis of this document allows us to consider that in the integral health approach to the older adults the fundamental concept is not “to cure” but “to take care of”, since the idea of “cure” accentuates the hegemony of medical knowledge and stresses the disease, with the additional problem of taxing the scarce resources that depend on technical and scientific development. The care approach gives primacy to the community, puts the accent on health and has a great advantage in that the resources on which leans are those of the knowledge of the community.

The actions must be developed with a **preventive criterion from the paradigm of health**. It demands the coordinated concurrence of several social actors to allow the construction of a **system of that values and respects the capacities and desires of the older adults** and of the community in which they live; thus we propose to complete the fundamental axes of the recommendations on the basis of the following concepts:



*The Gerontologic Plan and the Programs and Projects that are framed on it must focus towards **continuous, integral care**: physical, psychic, functional and social, **progressive, interdisciplinary, situational, intergenerational and inter-institutional**, sustained in the observation, the characterization of the population and its segmentation in risk groups.*

Considering, to define the necessities and to select the actions, the **predominant situation** of health, disease, functional dependency and/or social vulnerability in which the older adult is since, although in reality the situations are combined and there exists the possibility of journeying from one state to another, it is necessary to prioritize to define the suitable strategies and to rationalize the use of the resources.

9. References

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