Towards Age-friendly Primary Health Care

World Health Organization

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Contents

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WHO's "age-friendly" primary health care project aims to sensitize and educate PHC providers about the specific needs of their older clients. "Age-friendly Principles for PHC Centres" serve as a tool to increase provider awareness and empower older users of PHC centers.

The Age-friendly PHC symbol stands for action in three major areas:

- **improving the attitudes, education and training of health care providers so that they can assess and treat conditions that afflict older persons and empower them to remain healthy**
- **adapting PHC management systems to the needs of older persons**
- **making physical access easier for older persons who may have mobility, vision or hearing impairments.**

Imprinted on the nurse, a symbol for all PHC providers, is the logo used by the United Nations to move "Towards a Society for All Ages", the theme of both the 1999 UN International Year of Older Persons and the Second UN World Assembly on Ageing.

While age-friendly primary health care addresses the specific health needs of older persons, it also benefits people of all ages.

Executive Summary

The world is ageing. With people living longer and fewer children being born, the absolute number of older people is increasing. Today, worldwide, there are some 600 million persons aged 60 and over; this total will double by 2025 and will reach virtually two billion by 2050 when there will be more people aged 60 and over than children under the age of 15. The vast majority of older persons will be living in developing countries which are often least prepared to meet the challenges of rapidly ageing societies.

Increased longevity is a triumph for public health and the result of social and economic development. Unfortunately however, the rapidity of population ageing is expected to continue to outpace social and economic development in developing countries. In other words, developing countries will become old before they become rich while industrialised countries became rich while they were growing old.

With ageing comes an increased risk of developing chronic diseases and disability. Older people with disabilities, such as the grandfather who suffers a stroke from uncontrolled hypertension, will need help just getting through their daily tasks – help that is most often provided by families already stretched for time and resources. In order to prepare for unprecedented population ageing now, it is of utmost importance that health systems in developing countries are prepared to address the consequences of these demographic trends.

Hypertension, for example, is a chronic condition that can be controlled and managed. Dealing with the increasing burden of chronic diseases requires opportunities for health promotion and disease prevention in the community as well as disease management within health care services. Many chronic diseases and the associated disabilities that affect the later part of a person's life span along with their economic and human costs can be prevented. But prevention requires reaching the individual before the disease takes hold and that means intervening at earlier stages of life, i.e. taking a life course approach to active and healthy ageing which the World Health Organization defines as *the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age.*

Most preventive health care and screening for early disease detection and management takes place in the primary health care setting at the community level. These primary health care (PHC) centres, to which people can self refer, also provide the bulk of ongoing management and care. It is estimated that 80% of front-line health care is provided at the community level where PHC centres form the backbone of the health care system. Older people already account for a sizeable proportion of PHC centre patients and as populations age and chronic disease rates climb, that proportion will increase. PHC centres are on the frontline of health care and are thus familiar to older people and their families. They are ideally positioned to provide the regular and extended contacts and ongoing care that older persons need to prevent or delay disabilities resulting from chronic health conditions.

Despite the critical role that PHC centres play in older persons' health and well-being, older people encounter many barriers to care. Transport to the centre may be unavailable or too expensive. They may have to reach the centre early in the morning only to wait in long lines in uncomfortable settings just to get a number to be seen by the doctor or health care worker. They may encounter difficulty completing the required forms and overburdened staff may get impatient with them. After waiting for hours, they may get only a few minutes with a health care provider who does not have time to listen to all their concerns, misses critical warning signs, and does not have the geriatric-related training to make the right diagnosis or prescribe the right treatment. They may not be able to afford the medicines prescribed or may not understand why to take them or what side effects to report. Older patients may become discouraged from seeking or continuing treatment with potentially serious health consequences.

The World Health Organization has recognized the critical role PHC centres play in the health of older people worldwide and the need for these centres to be accessible and adapted to the needs of older populations. By working with a series of national groups, WHO has gone to the source, asking older people and their providers to describe their barriers to care and their suggestions for change. These focus groups results, backed up by background research and a consensus meeting of experts, led to the development of a set of Age-friendly Principles.

It is important to remember that, while Age-friendly Principles primarily benefit older populations, they also enable people with temporary or permanent functional limitations to access needed care and to maintain health and independence. An Age-friendly Health Care Centre does not favor older people, but instead benefits all patients in line with the slogan of the United Nations International Year of Older Persons "Towards a Society for All Ages".

The Age-friendly Principles are designed to serve as a guide for community-based PHC centres to modify management and clinical services, staff training and environments to better fit the needs of their older patients. The Age-friendly Principles address three major areas:

- **Information, Education, Communication and Training**, including staff training in clinical geriatrics and approaches to patient education;
- **Health Care Management Systems**, i.e. adapting procedures, such as registration, to the special needs of older persons and supporting continuity of care through updated medical records available at each visit;
- **The Physical Environment**, i.e. clean and comfortable centres that apply, as far as possible, the principles of Universal Design.

An "Age-friendly Tool-kit" with information on training materials is currently being tested and will support the implementation of the Age-friendly Principles by PHC centres.

As the world's population ages, there are tremendous opportunity costs to be incurred through outdated PHC systems that do not fit the needs of growing numbers of older persons and that do not take into account the factors which influence health and disability levels. The onset of disability must be delayed or prevented for as long as possible if the success story of increased longevity is to be a time for independence, rather than dependence, activity rather than inactivity, and participation rather than marginalization from family and community life. The Age-friendly PHC centre constitutes a central component of this eminently achievable success story.

I. Introduction

In April 2002 in Madrid, Spain, Government representatives from 159 countries gathered for the Second UN World Assembly on Ageing and adopted the Madrid International Plan of Action on Ageing. The International Plan's call to action outlines steps to change attitudes, policies and practices on ageing at all levels and in different sectors so that older people can remain healthy, active and productive. The Plan approaches population ageing as an enormous potential and a dividend yet to be realized by societies around the world.

Advancing Health and Well being into Old Age is one of the three critical priority areas highlighted in the Plan. Governments recognized that older people are entitled to health promotion and disease prevention and that health services should focus on preventive and curative care throughout life, including old age. Specifically, the UN Plan called on Governments to develop and strengthen PHC services to meet the needs of older persons.

Concomitantly to the UN World Assembly, WHO launched its *Policy Framework on Active Ageing*. The Policy Framework builds on the premise that the vast majority of older persons, as indeed people of all ages, aspire to be active contributors and participants in society. They want to remain in good health and enjoy good quality of life for as long as possible. They also want the security of knowing that, if and when they become frail, they will enjoy the protection and the security they need. The Policy Framework defines *Active Ageing* as *the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age.* The *Active Ageing* approach builds on the life course perspective which recognizes the important influences of earlier life experiences, gender and culture on how individuals age. It takes into account the determinants of health to include the behavioural, environmental, social, economic, biological and psychological processes that operate across all stages of the life course and determine health and well being in later life. Among these determinants is life-long access to health care services, especially primary health care (PHC).

In addition to building on these two documents, i.e. the International Plan of Action on Ageing and the WHO Policy Framework, this brochure brings together two important areas of WHO work relating to (1) the importance of primary health care, and (2) how to adapt such care to the specific needs of different population groups.

While there is no uniform, universally applicable definition of primary health care, it is useful to understand PHC as involving both core principles, such as universal access to care, equity and community partici-

pation, and the first level of care provided at the community level. WHO describes PHC as the principal vehicle for the delivery of health care at the most local level of a country's health system.

> PHC is essential health care made accessible at a cost the country and community can afford with methods that are practical, scientifically sound and socially acceptable. Primary health care must be accessible and "friendly" to persons of all ages.

The second area of WHO work refers to tailoring care, identifying specific barriers, and making it "friendly" to the special needs of specific population groups. The conceptual origins of the "age-friendly" community-based PHC project may be traced to other WHO initiatives. In 1992, WHO and UNICEF launched the "Baby-friendly Hospital Initiative" as a primary intervention strategy for promoting breast-feeding and for strengthening national health systems. WHO's "Adolescent-friendly Initiative" (2002) and the related "Integrated Management of Adolescent and Adult Illness" (2003) pursue more widespread aims and objectives, which are more similar to those of the age-friendly project.

The age-friendly primary health care project aims to sensitize and educate PHC workers about the specific needs of their older clients. The Age-friendly Principles for PHC Centres (Annex II) serve as a tool to increase health literacy and to empower all users of PHC centres, in particular older persons. The primary objective of this booklet is to make the local PHC centre more aware of and more suited to the needs of older persons and the types of care they require.

II. The Need for Age-friendly Primary Health Care

The demographic imperative. A demographic revolution is under way throughout the world. Today there are about 600 million people in the world aged 60 and over. By 2025 this total is expected to double and by 2050 it is projected to reach two billion or 21 percent of the total global population. Such accelerated global population ageing will impact social and health care demands in all countries.

Population ageing is driven by two factors: an increase in the proportion of adults aged 60 and over as mortality rates decline, and a decline in the proportion of children reflecting declines in total fertility rates (TFR) in the overall population. Today over 60 percent of the world's older persons 60 and over live in the developing world. By 2025 that figure will rise to 75 percent and 85 percent in 2050. However, the speed and impact of population ageing in the less developed regions are yet to be fully appreciated. Moreover, among the older population worldwide, the fastest growing group is the oldest old, those who are 80 years or more.

By 2025 in countries such as China, Brazil and Thailand, the proportion of older people will be above 15 percent while in Indonesia, Colombia and Kenya the absolute numbers will increase by up to 400 percent in the next 25 years, i.e. up to eight times higher than the increases experienced by already aged societies in Western Europe where population ageing occurred over a much longer period of time.

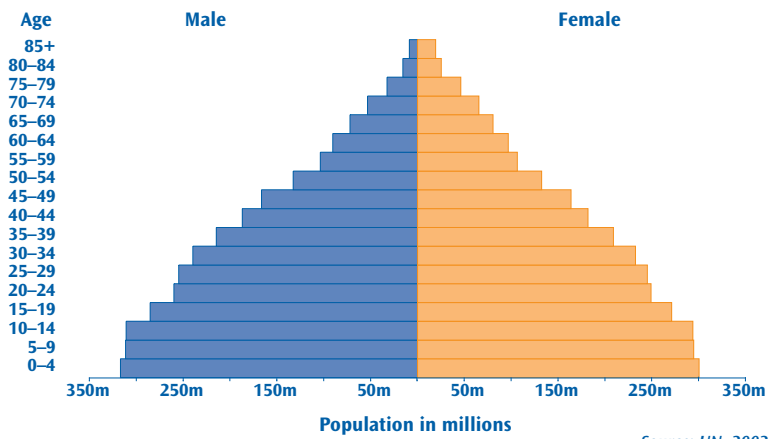
The epidemiological transition. The developing world continues to face the burden of persistent infectious diseases while the prevalence of risk factors for chronic diseases is also on the increase – all within the context of under-resourced health and social systems. Although many individuals can now look forward to longer lives, the risk of having at least one chronic disease, such as hypertension or diabetes, increases with age. This is not so much a function of chronological age *per se* but a reflection of the life-long accumulation of risk factors for such diseases which reinforces the importance of health promotion and disease prevention throughout the life course.

Patterns that lead to disabilities and chronic illnesses are costly in economic and human terms to individuals, families and society. A life course approach including healthy lifestyles and due recognition of the impact of environmental, socio-economic and other conditions, can break the cycle that leads to many disabling diseases later

Ageing is definitely no longer a first world issue. What was a footnote in the 20th century is on its way to becoming a dominant theme in the 21st.

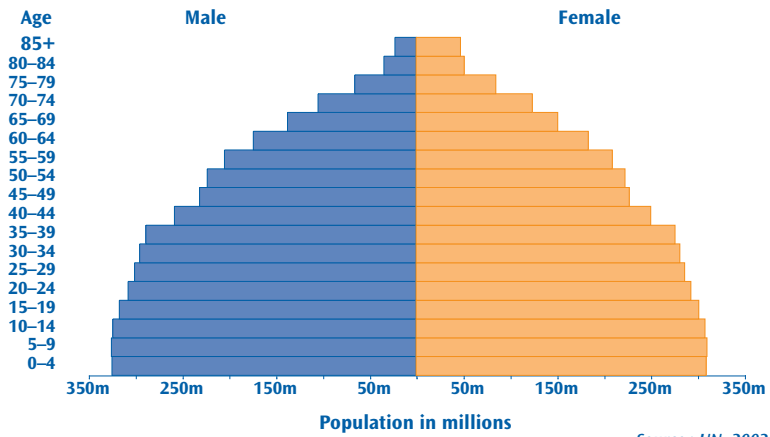
Kofi Annan,
UN Secretary General

Figure 1. World Population Structure 2000



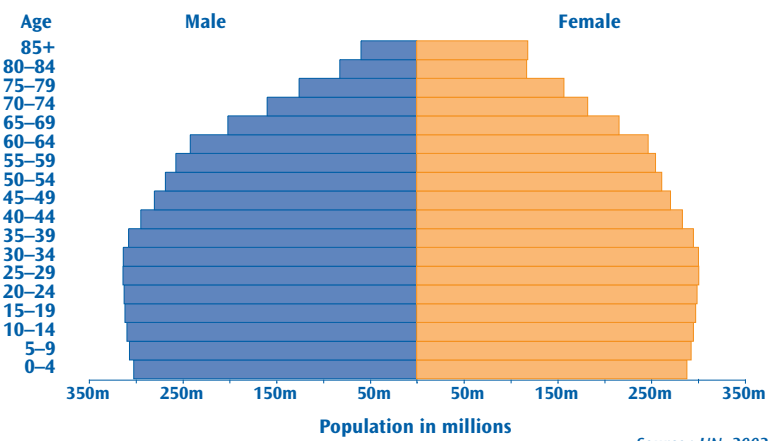
Source: UN, 2002

Figure 2. World Population Structure 2025



Source : UN, 2002

Figure 3. World Population Structure 2050



Source : UN, 2002

World population prospects: the 2002 revision (United Nations).

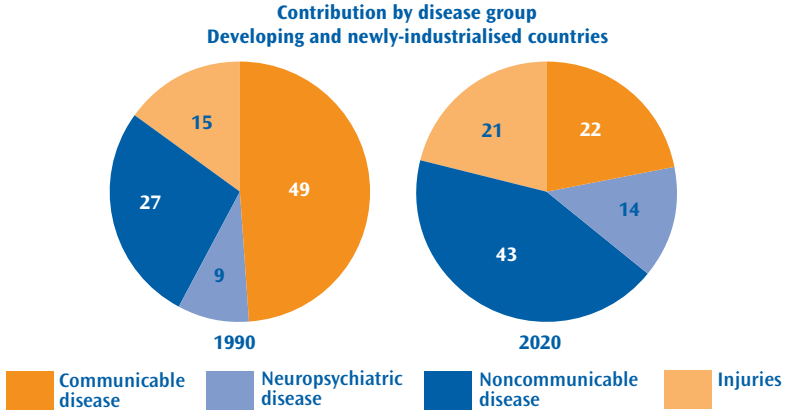
in life. Once older people develop these diseases, they must be closely managed through community-level interventions, such as ongoing care, medication management, and health education to prevent potentially catastrophic consequences. From midlife (45 years and older), chronic diseases make up the vast majority of all diseases and are responsible for most deaths anywhere in the world. There are proven strategies that can change the future picture from overburdened health and social systems to older people living longer, more healthily and more productively. Primary prevention strategies, biomedical advances, behavioural management – all can significantly improve the ability to prevent and control chronic diseases such as diabetes, cardiovascular disease and cancer.

Most health care, particularly at the PHC level, is currently organized around an acute, episodic model of care – a model that does not meet the needs of many patients, especially older patients with chronic diseases. Moreover, although the community setting, where the vast majority of older people live, provides the bulk of care, it receives only a fraction of health care resources.

The 2002 WHO report, *Innovative Care for Chronic Conditions: Building Blocks for Action* proposed a comprehensive framework for updating health care systems to meet changing population needs and the need for affordable chronic disease management.

The Report called for a paradigm shift that moves resources and focus to prevention, early intervention and ongoing health care management – all critical to effective management of chronic diseases and care of older people. Moving a higher proportion of resources to the community setting for prevention and for ongoing management of chronic diseases will result in a better return on investment.

Figure 4. Global Burden of Disease 1990–2020

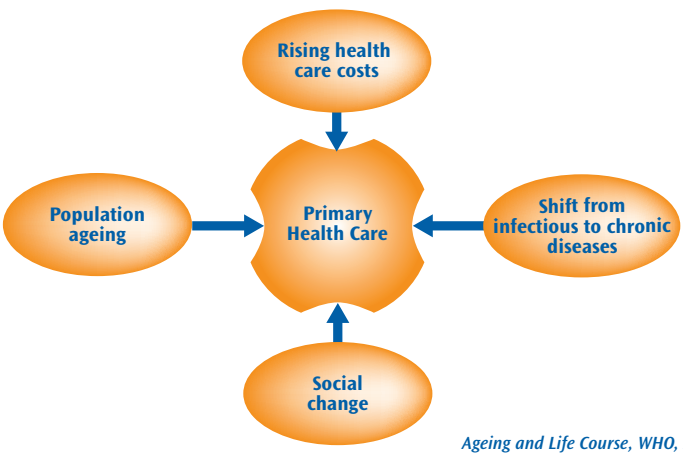


Murray CJL, Lopez AD. (1996). Quantifying the burden of disease and injury attributable to ten major risk factors. In: Murray CJL, Lopez AD, eds. *The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020.* Harvard School of Public Health on behalf of the World Health Organization and the World Bank (Global Burden of Disease and Injury Series, Vol. 1).

Economic pressures. Opportunities missed by health systems to deal with the accumulation of risk factors or to manage age-related chronic diseases will lead to increases in the incidence, prevalence and complications of these diseases and may take resources away from other priorities. An older population in good health releases resources which can be used for other needs, such as child and maternal health. While healthy ageing is important for developed countries so that health care spending can be controlled, it is vital for developing nations where health care resources are sorely lacking. Primary health care plays a critical role towards achieving healthy ageing objectives.

Social change. Traditional societies in developing countries are changing rapidly. Family and social support are eroding due to a variety of factors related to rapid social change, including rural/urban migration by younger family members, changing family patterns, shrinking family size, and higher levels of female labour force participation. In the absence of social security and other formal social support programmes that exist in more developed countries, frail older people in low-resource settings are at considerable risk. All of these factors create the need for change in PHC centres so that they can better address the needs of their older clients.

Figure 5. Pressures on Primary Health Care



Ageing and Life Course, WHO, 200y

III. Towards an Agenda for Change for the PHC Centre

Defining a PHC centre. There are many versions of community-based PHC centres among countries and particularly between urban and rural settings. In Australia and Canada, for instance, the bulk of community health is provided by general practitioners. In Jamaica, community-based care is delivered both by doctors in private practice and in government-operated clinics. Community health care in the Philippines takes place in health units, government hospitals, village health stations as well as at NGO-run clinics, while Singaporeans get most of their care from GPs or government-run polyclinics located across the island.

Some PHC centres are located in shopping centres, others in health stations or rural health units, others, such as those run by an NGO in Delhi, are mobile vans that travel from neighborhood to neighborhood on a set schedule. They may be public or private, large or small and offer a range of services including consultation with doctors, nurses and other health care workers, laboratory investigation and X-rays, medications, counseling, treatments, referrals and health education programmes – or, as in some developing countries, only consultation services by volunteer health workers.

Yet, for the most part they share some common characteristics – they operate on an outpatient basis; they are often the first point of contact with the health care system; they tend to be located near where their target population lives and, in general, they provide more low-tech than high-tech diagnostic and treatment services.

The PHC centre – at the forefront of care for older persons. Most PHC centres are busy places where nurses, physicians and other health and social workers are short of time and resources. It is therefore important that they use their limited time and resources most efficiently. For example, it is not uncommon for an older person to present multiple, sometimes confusing symptoms that need a provider with at least a basic knowledge in the care of older people to decipher the root causes. Symptoms may include dizziness, breathlessness, difficulty walking or bending, decreased sensation in legs and feet, changes in appetite, pain, and confusion – the list goes on. These may be early manifestations of diseases or warning signals for impending problems which require a timely and effective response from the PHC worker.

Early detection, appropriate intervention, management and planned follow-up can prevent many disastrous consequences. An older woman with diabetes for example can keep her foot if her blood sugar is tightly monitored and controlled, and she and her family are taught self-management techniques, such as foot care. As a result, complications of diabetes can be managed and controlled.

PHC practitioners should also be well versed in the diagnosis and management of the well known four "giants of geriatrics", the most common conditions of older people: falls, incontinence, immobility and confusion. They need to be aware that medical problems often present differently in older people. Infections may be present without fever, or depression without feelings of worthlessness or guilt, common in younger patients. In general, symptoms in older people – including perceptions of pain – are often less dramatic and less specific than in the young and therefore harder to diagnose. Some practitioners tend to dismiss symptoms by simply attributing them to old age.

Even though health or medical issues are the priority of the doctors or nurses in the PHC centre, they are often not the priority for their older patients, who may be more worried about paying next month's rent or feeding their grandchildren. Community-based PHC centres are also the right place to support coordinated social care – access to income support for medicine, links with housing services, food or home help services – that address the social and economic needs of the older person. If these needs are not addressed, it will be more difficult for older persons to take charge of their own care, wasting scarce health care resources and resulting in more suffering.

Clearly, obstructive management procedures, medical and nursing staff poorly trained in the treatment of older persons, negative attitudes towards older patients, high cost of treatment and medications, lack of coordination with social services, all create an environment which discourages older people from returning for treatment and affects the outcome of care.

Consulting older people and their providers about improving care. In the quest for improving health services, health planners and policy makers often neglect to ask older people themselves what problems they encounter in using community-based health care and what might be their ideas for change. The same applies to frontline providers – doctors, nurses, health care workers, receptionists and other staff working day-in and day-out in health care centres. Both users and care providers are seldom consulted on their experiences or how systems need to change to improve care.

The views of older people and care providers are central to developing principles that render community health centres more age-friendly and more responsive to the patients and the communities they serve.

Towards this aim, WHO organized a series of focus groups in a range of developed and developing countries in different parts of the world, namely Australia, Canada, Jamaica, Malaysia and the Philippines. A total of 36 groups of older people with over 300 participants and 8 provider (nurses and doctors) groups with over 50 participants were conducted in 2002.

The review of the results revealed remarkable consistency across all participating countries, in both central and remote areas.

Older people and their providers shared many of the same concerns. These commonalities suggest that the problems experienced by older people in the participating countries are global in nature and would benefit from the same general principles of care and management.

What older people and their health care providers said about care. The rich information gained from the focus groups highlighted three key themes underlying age-friendly health care centres. These themes and the relevant recommendations are summarized as Age-friendly Principles for Community-based PHC Centres. They are not meant to replace, but raise awareness and supplement other management and clinical policies and procedures. They are sufficiently generic to be applied in most health care settings in most countries. They will, however, need to be tailored or interpreted to best suit each circumstances and settings. The Principles address each of the areas below:

1. Attitudes. Older people talked about their negative and often humiliating experiences at health care centres. Short staffing and sometimes insensitive staff translated into disrespectful, dismissive treatment across the board – from front desk workers to nurses and doctors. They discussed waiting for hours only to be hurried through short appointments with distracted providers who had no time to listen to their concerns. There was time for only one problem and they were told to come back again to address others. Their complaints were often dismissed and their symptoms ignored.

> ***...he said, "I am the doctor here and I will tell you what is wrong with you"*** (older person, Australia).

Older people also said they wanted a provider with a caring attitude who showed they cared about them, "had patience" and "were willing to spend time with you" and with whom there would be "good communication on an equal basis". What they experienced was sadly often the opposite. They were willing to make excuses – citing not enough staff and poor pay and conditions – but they plainly suffered from the way they were treated.

> ***Just the look on the nurses' faces, you don't want to ask questions.*** (Older person, Jamaica)

> ***Older people and the young suffer the most from this unfriendly system.*** (Provider, Jamaica)

An age-friendly approach was described as:

> ***She listens; she treats me as an equal.. we discuss things; she gives me choices….the freedom to make the choices that I want…***

2. Training and education. One of the most significant barriers to health care is the lack of trained health care providers. Training is linked to attitude and skills and directly correlates with the quality of care provided and therefore to the outcome of care. Older people wanted to have confidence in their providers and to feel that they were competent in diagnosis and treatment. They wanted "somebody who knows what he doesn't know and looks up answers";

somebody who will get to the root of the cause", "knows what he is talking about", "and asks questions". They also wanted to understand their diagnoses and especially their medications.

> ***Sometimes the doctors just give medication…without really explaining unless you ask.*** (Older person, Malaysia)

Providers, on the other hand, reported feeling frustrated about not having enough time or having difficulties in explaining preventive care and chronic disease management to many of their older patients, particularly those with low education or with hearing impairments. They said many older people expected illness and disability as inevitable with old age and did not understand that their function could be improved with treatment.

> ***Many patients tell me, "I'm so old already, so I expect to have joint pains...it's because of old age".*** (Provider, Malaysia)

Many doctors, nurses and other providers did not work effectively as a team, resulting in gaps in communication, assessment and treatment and inefficient use of scarce manpower resources.

> ***When my wife goes to the doctor and something is not working he just adds another medication to the list…some of these probably fight each other and there is an adverse effect on the system.*** (Older person, Australia)

Providers themselves discussed their need for training – in diagnosing the subtle yet complex symptoms of chronic care, managing several conditions at once and choosing appropriate treatments and medications for older patients.

> ***Most of us would have a basic knowledge of how to deal with elderly patients but some courses or workshops would be of value.*** (Provider, Jamaica).

Providers were also concerned about their own best use of time and practical reimbursement issues

> ***Providing health education is time consuming. This is a 'bread and butter issue'. You have to be adequately remunerated.*** (Provider, Malaysia).

The age-friendly approach was stated by a user:

> ***Doctor sat me down and explained how dangerous it was. No doctor ever do that before. She explains that if I do not change my habits I will have to go to insulin.*** (Older person, Jamaica)

3. Gender issues. More older women than older men seek health care and this proved true in countries as diverse as Jamaica and Australia. Yet, older women's "female" concerns were often trivialized while some older men said they see doctors only when their symptoms can no longer be ignored.

> ***I had a complaint but no doctor would listen to me. I was losing a lot of my hair and it turns out that I was actually suffering from a serious hormonal imbalance but it took six months to see something was wrong.*** (Older woman, Canada)

> ***Men aren't like women, women go in normally once a year and have blood tests and mammograms and off we go but men don't like doctors and that is understandable.*** (Older person, Australia)

4. Language. Being able to speak the same language is basic to effective communication between providers and patients. Yet, many of the older patients and providers did not share a common language or had no interpreters available to help. This is especially true in countries such as Malaysia where many languages and dialects are spoken.

> ***When we cannot communicate with them, they get angry and they look down on us…We do not know how to express our feelings and explain to them our sickness. If the doctors do not understand our language, they cannot ask us questions regarding our health.*** (Older person, Malaysia)

Impaired vision or hearing are common in older people and can negatively affect effective communication and therefore history taking, diagnosis and treatment. Simple techniques such as eliminating background noises, face to face speech in clear tones, and providing adequate lighting will allow older people to respond to questions. These techniques can be taught to doctors, nurses and other health care workers and used in most settings. Communication is the first step to effective treatment.

The General Principles

In the areas of information, education, and training:

- All PHC centre staff should receive basic training in age, gender, and culturally sensitive practices that address knowledge, attitude and skills.
- All clinical staff in the PHC centre should receive basic training in core competencies of elder care.
- PHC centres should provide age, gender and culturally appropriate education and information on health promotion, disease management and medications for older persons as well as their informal carers in order to promote empowerment for health.
- PHC centre staff should review regularly the use of all medications, including complementary therapies such as traditional medicines and practices.

5. Obstructive management systems. From their comments, it often became evident that older people thought health care centres or clinics put obstacles in their path rather than ease their way towards treatment. Being shunted from line to line, being required to present extensive documentation to apply for subsidies, inconvenient appointment times and long waits as well as having to go to more than one facility for treatment – all represent significant deterrents and barriers to care. Older people

with low or no literacy skills or those with visual or hearing problems may find the whole process overwhelming and just give up.

Cost and affordability of medical care, medications, even transport to the health centre are big concerns for older people, especially those with low incomes. Many do not seek or delay needed care because of worries about cost. Many revealed that they did not want to burden their children or take scarce family resources away from grandchildren so treatment was delayed as much as possible.

Lack of resources across the board, including insufficient numbers of trained staff and diagnostic services, funding for and systems to stock medications, as well as money to upgrade centres, all lead to overburdened staff with insufficient time for a caring and comprehensive examination, let alone health education or prevention efforts. The outcome on the patients can be disastrous.

> ***I am ashamed to ask my children, so…I have to bear the pain. Be patient…bear the pain.*** (Older person, Philippines)

> ***Our services can do more for older people provided the issue of payment is tackled.*** (Provider, Malaysia)

6. Cost. The cost of consultations, diagnostic services and particularly the high cost of medicines were specific areas of concern. Older people also talked about being prescribed too many different types of medicines whose use was not explained. A large part of "non adherence" with medications, such as not taking the medications prescribed or only half the dose, is connected to cost. Cost is also related to older persons being able to reach the centre at all, i.e. that they can walk to public transportation and that transportation is available and affordable.

Complicated administrative procedures and fragmentation of services worsens the issue of expensive polypharmacy. Participants shared stories about how the medications they were prescribed were not "on the (subsidized) list" or not available in many centres. They spoke of restricted numbers of pharmacies dispensing subsidized medications; of being ineligible for subsidy; of being given only two-week or one-month supplies of medications; and the difficulties of returning to the dispensary for refills. Above all, they complained of being unable to afford the medications prescribed by their doctors.

> ***I had to leave some of the prescription because I didn't have enough money, they are too dear and I still haven't gone for them.*** (Older person, Jamaica)

> ***Many of the elderly come back to the clinic with 2-3 prescriptions not filled, sometimes it's money and other times they do not remember.*** (Provider, Jamaica)

7. Waiting time. Waiting time was also high on the list of frustrations and interfered with receiving care – both waiting to get an appointment and waiting time to see the provider. Older people suggested giving an estimate of the waiting time or a staggered appointment system so all did not need to arrive in the morning and wait all day.

> ***I went for a check-up in the morning and ended up coming back home at 5pm. Even a normal person can get sick of this waiting time.*** (Older person, Malaysia)

> ***When the numbers for the day finish, they say come back another day.*** (Older person, Jamaica)

The age-friendly approach was expressed by:

> ***I think they should be given a specific date and time to consult the doctors.*** (Provider, Philippines)

8. Appointment times that are too short for complete assessment and treatment. A lack of providers and larger numbers of patients in a packed clinic schedule translate into short appointment times. Older people related that doctors listened to only one complaint and had no time for their other concerns. Quality care for older persons implies having enough time for consultation. The piecemeal approach to care is of great concern and may result in missing warning signs of incipient medical problems.

> ***I was amazed at the short interviews so I started timing them, two and a half minutes…*** (Older person, Australia)

Given the long queues the older patients felt unable to ask for a check-up and were often told to "make an appointment for that" – another discouragement for prevention, early detection and health promotion.

> ***Clinic doctors don't have time, only deal with the thing you have an appointment for, they won't give you a check-up or deal with another complaint.***

Providers felt equally frustrated:

> ***We would like to spend more time with the patients but it is very difficult. You have 40 patients and you are looking at 10 minutes maximum per patient.*** (Provider, Jamaica)

For the providers, the lack of time was worsened by the lack of medical records with information on history, treatment and medications.

> ***Lack of time would not be a barrier if there was a system that helps the general practitioner recall the elderly patients' past records.*** (Provider, Malaysia)

9. Lack of continuity and fragmentation of service. Many older participants reported that they rarely saw the same provider and missing medical records meant that the provider was not familiar with their history. Some found it hard to pay another fee for a consultant physician and found that the doctors did not always communicate their information to each other.

> ***I attend a clinic where they have about a dozen doctors…The only problem is that the doctors do not seem to be permanent…and then the whole examination begins again.*** (Older person, Australia)

> ***I don't feel like I have a family doctor…I'd just like them to stay a little longer so you can have a relationship with the doctor.*** (Older person, Canada)

They also experienced the lack of coordination between specialist, hospital and community-based providers and reported that their community physician did not have information about their hospitalizations and medications prescribed.

You pay for the eyes, for the throat…you may have as many as seven doctors so you have to pay seven professional fees. (Older person, Philippines)

He said, "Here are two medications I want you to take…but go to your doctor and get them checked". I went there and he said, "I want you to take more medications". Then the doctor from the geriatric ward… he put me on two more medicines… (Older person, Canada)

The providers also complained:

There is no coordination of care between hospitals and GPs. We get no letter or feedback…not even a phone call. (Provider, Malaysia)

10. Special clinic or consultation hours for older persons. There was much debate over whether to have special clinic hours for certain groups of patients, such as adolescents or older people. Many of the older people interviewed requested special clinic or consultation times. They felt that special clinics might result in shorter waits, enable the doctor to focus on their special needs and give them a safer and more comfortable clinic atmosphere.

I want to come only when seniors come. Yes, the young ones are too noisy and do bad, unacceptable things. (Older person, Jamaica)

A similar view was expressed by some providers:

They come late because of the distance and can go home without being seen. They should have their own day so everyone who comes can be seen. (Provider, Jamaica)

The General Principles

In the area of community-based health care management systems:

- PHC centres should make every effort to adapt their administrative procedures to the special needs of older persons, including older persons with low educational levels or with cognitive impairments.
- PHC systems should be cost sensitive in order to facilitate access to needed care by low income persons.
- PHC should adopt systems that support a continuum of care both within the community level and between the community and secondary and tertiary care levels.
- PHC centres should put into place mechanisms that facilitate and coordinate access to social and domiciliary care services.
- All record keeping systems in PHC centres should support continuity of care by keeping records on community-based, secondary and tertiary care as well as on the provision of social services for their clients.
- All relevant stakeholders, including older persons, should be part of participatory decision-making mechanisms regarding the organisation of the community-based care services.
- Information on the operation of the PHC centre, such as opening hours, fee schedules, medication and investigation charges, and registration procedures should be provided in an age-appropriate way.

11. The physical environment. Older people face many physical barriers to reaching the care facility as well as navigating it. Many individuals, especially in rural areas, face long distances or inaccessible transport that they can ill afford. Many health centres are not set up for or are "unfriendly" to frail older people or those with disabilities. Exam rooms often have narrow doors or are too small to accommodate wheelchairs and assistive devices, such as walkers. This makes it difficult to get an older person on the exam table and even discourages doctors from giving a complete examination. Some health centres were reported to be dirty and uncomfortable, with inadequate toilet facilities or lacking options to get drinks or food during the long hours of wait.

> ***Improve facilities at health centres to make them more elder friendly.*** (Older woman, Jamaica)

Distance from the PHC centre was a problem common to many.

> ***The distance is a big problem particularly for people on their own.*** (Older person, Australia)

> ***I am weak and can't walk the distance and do not have the money for a taxicab.*** (Older person, Philippines)

If older persons needed to rely on someone to accompany them to the centre, it often meant they did not go.

> ***I don't go because I need somebody to take me. Children are all working. I don't want to bother them.*** (Older person, Malaysia)

The providers also recognised this as a potential problem:

> ***Transport is a big issue because if you have someone who was coughing and had incontinence how could she catch the bus to get down to see me?*** (Provider, Australia)

Some exam rooms were too small to fit a wheelchair or the older person could not get on the examination table because there was no stool to stand on.

> ***Facilities are not geared for older people, for example you have steps instead of ramps, chairs without arms...*** (Provider, Jamaica)

> ***One of the gentlemen had a stroke and cannot sit for very long. He wants to go home. We cannot manage to lift him and we do not have a wheelchair.*** (Provider, Jamaica)

Noisy, unclean and crowded health care centres can be very confusing places. Also, many of the signs in the health care centre are unclear and hard to read. Walking long corridors in the wrong direction and finding it hard to find someone to direct you to the right place definitely discourages care. Older people also found it difficult to tell one staff from another.

Many older people said they would not mind waiting if there were some amenities such as fans (or heating) and comfortable chairs that they could get in and out of. Cleanliness was also a big concern. Clean centres and well presented providers instill trust and confidence.

The first thing I notice is it has a clean environment and facilities. I believe that as soon as they get hold of the patient, I know he will get better because it is clean. (Older person, Philippines)

They need to put a bench with a cushion, not the old concrete thing…and open the bathroom. (Older person, Jamaica)

The General Principles

In the area of the physical environment:

- The common principles of Universal Design should be applied to the physical environment of the PHC facility whenever practical, affordable and possible.
- Safe and affordable transport to the PHC centre should be available for all, including older persons, whenever possible, by using a variety of community-based resources, including volunteers.
- Simple and easily readable signage should be posted throughout the PHC centre to facilitate orientation and personalise providers and services.
- Key PHC staff should be easily identifiable using name badges and name boards.
- The PHC facility should be equipped with good lighting, non-slip floor surfaces, stable furniture and clear walkways.
- The PHC facilities, including waiting areas, should be clean and comfortable throughout.

IV. Beyond the PHC Centre: Macro Issues of Age-friendly Health Care

It must be recognized that the issues that impact on older people's health go well beyond the walls and scope of the community-based PHC centre. Social policies, legal protections, education, safe and clean environments, housing, income security and opportunities for work as well as supportive networks are some of the other basic approaches to achieve improved well-being and quality life at older ages.

Issues of gender and culture, of equity, of investment and resource allocation, of integration and coordination across the health care system, of training families and professional caregivers in caring for the older person – all these must be discussed and addressed at the policy and health planning level. The UN International Plan of Action on Ageing 2002 and the WHO Active Ageing Policy Framework provide a framework – governments and civil society must do the implementation. Some of the critical issues underpinning the evolution of health care systems into more responsive providers of care that address the changing needs of people living into old age in health and wellness are summarised below:

Gender and ageing. While older women and men are afflicted by the same basic chronic diseases, such as cardiovascular diseases, diabetes, musculoskeletal problems, and incontinence, health care for older people has a very important gender dimension. Rates, trends and specific types of diseases differ between men and women – and that is not only because of biological characteristics but also due to the impact of socially determined roles and responsibilities, i.e. gender divisions and gender roles. Generally, women live longer than men and women represent the majority of caregivers for frail spouses or family members. After having cared for husbands and other family members, older women often find themselves without financial or caregiving support when they themselves grow frail or dependent.

On the other hand, there is also growing evidence that the health needs of ageing men are often neglected and special outreach programmes for older men are needed.

The complex patterns of roles, responsibilities, norms and values in a given society and their impact on the health of men and women as they age need to be better understood. Community-based health care must ensure that attitudes, services and relevant policies integrate both age and gender concerns.

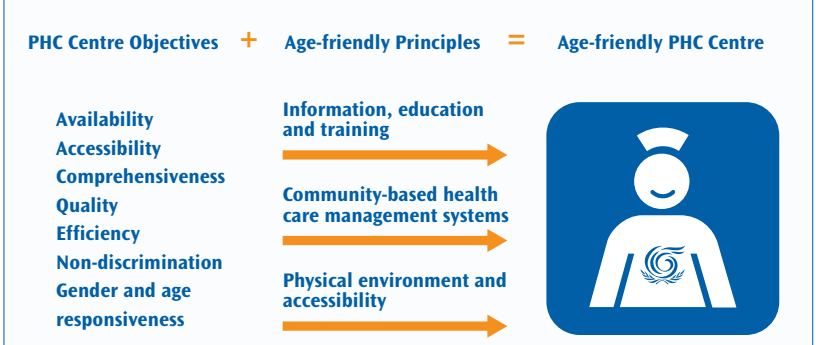
Cultural diversity. Age-friendly, community-based health care must be responsive to cultural diversity and sensitive to the concerns of all health care users, including older persons. Health care which recognizes cultural diversity within countries and regions and which is sensitive to the needs of people of different languages, health

practices and beliefs will be more responsive and present less barriers to care. While this may require the targeting of some resources – both human and financial – culturally sensitive policies are also needed for the promotion of better health outcomes and for the empowerment of older persons, their families and community networks.

Integrated approach to public health and health care. The health sector does not have sole responsibility for policies in all sectors. An integrated approach stresses the importance of the numerous different public health partners and reinforces the role of the health sector as a catalyst for action.

At the macro policy level, age-friendly community-based health care will help promote an integrated approach to public health and health care. The General Principles on Age-friendly PHC Centres must therefore be fully integrated into relevant health and social policies at the national and local levels at all stages of policy making and implementation.

Figure 6. Developing Age-friendly PHC Centres



Ageing and Life Course, WHO, 200y

Across government and civil society, many authorities and organisations create and implement policies and strategies that affect health. The policies of all sectors need to be analyzed and aligned to maximize health outcomes. Health care can be and should be aligned with policies on employment and labor, finance, social security, housing, transportation, justice, rural and urban development and broader legislative frameworks. Older people and civil society organizations which represent them must be consulted as their views can make important contributions to achieve greater satisfaction with the services offered.

Investment and adequate budget allocation. The long-term benefits of investment in community-based primary health care, including health care of older persons, must be recognized and supported by national governments with adequate budget allocation and training for professionals and informal caregivers.

Supporting and training the informal caregivers. Training of both informal or family caregivers and professional staff is a basic building block to supporting healthy aging policies as well as providing appropriate medical and social care. Across the world, family members are the major caregivers of older people. They must be trained in how to keep older people healthy through health promotion practices such as good nutrition, safe environments and falls prevention. Once they are faced with caring for a dependent or ill older person, they need training to understand the illness, the medications and the treatment. Most of all, they need both formal and informal assistance with coping skills and strategies that support family care.

V. Conclusion

Age-friendly PHC services, supported by well-trained nursing and medical staff, promote and value the role of patients and their families as active partners in managing health. Age-friendly PHC providers are in a key position to develop long-term relationships with patients and whole families. Through extended contact they can gain their trust and offer primary prevention, i.e. intervening before health problems occur, through programmes such as risk factor management. They are also in line for secondary prevention or screening to detect conditions, such as diabetes, hypertension, and some forms of cancer and intervene at early stages to minimise the impact and associated disabilities. Physical health and freedom from disability is the single most important asset for most older people and is closely linked to their ability to work, to function independently and to continue to contribute to their families and societies. Trained providers can reduce the number of inaccurate or missed diagnoses that lead to adverse health outcomes. Barriers to care must be broken down in order to provide the kind of comprehensive care necessary to improve the health of older people. The PHC centre is key for achieving these goals.

While Age-friendly PHC Principles are intended to serve the needs of older populations, they also enable people of all ages with temporary functional limitations to access needed care and maintain health and independence. An Age-friendly PHC Centre does not favour older people but benefits patients of all ages in line with the slogan of the 1999 UN International Year of Older Persons to move "Towards a Society for All Ages."

Bibliography

Alaszewski A, Billings J, Coxon K (2004). Integrated health and social care for older persons: theoretical and conceptual issues. In: Leichsenring K, Alaszewski A, eds. *Providing integrated health and social care for older persons: a European overview of issues at stake.* Aldershot, Ashgate Publishing: 53–94.

Ben-Shlomo Y, Kuh D (2002). A life course approach to chronic disease epidemiology: conceptual models, empirical challenges and interdisciplinary perspectives. *International Journal of Epidemiology*, 31:285–293.

Brodsky J, Habib J, Hirschfeld M. (2003). *Key policy issues in long-term care*. Geneva, World Health Organization (http://whqlibdoc.who.int/publications/2003/9241562250.pdf; accessed 22 June 2004).

Kalache A, Aboderin I, Hoskins I. (2002). Compression of morbidity and active ageing: key priorities for public health policy in the 21st century: public health classics. *Bulletin of the World Health Organization*, 80:243–244 (http://whqlibdoc.who.int/bulletin/2002/Vol80-No3/bulletin_2002_80(3)_243-250.pdf , accessed 22 June 2004).

PAHO/WHO (2003). *Global meeting on future strategic directions for primary health care. Primary health care and human resources development, Madrid, Spain, 26 and 27 October 2003.* Washington, DC, Pan American Health Organization (http://www.who.int/chronic_conditions/primary_health_care/en/human_resources_en.pdf, accessed 22 June 2004).

WHO (1994*). Health care for the elderly: a manual for primary health care workers.* Alexandria, WHO Regional Office for the Eastern Mediterranean (WHO Regional Publications, Eastern Mediterranean Series, No. 10).

WHO (1998). *District health facilities: guidelines for development and operations.* Manila, WHO Regional Office for the Western Pacific (WHO Regional Publications, Western Pacific Series, No. 22).

WHO (1999). *Health centres: the 80/20 imbalance burden of work vs resources*. Geneva, World Health Organization (WHO/HSD/99.3; http://whqlibdoc.who.int/hq/1999/WHO_HSD_99.3.pdf, accessed 22 June 2004).

WHO (2001a). *Innovative care for chronic conditions: meeting report, 30–31 May 2001.* Geneva, World Health Organization (WHO/MNC/CCH/01.01; http://whqlibdoc.who.int/hq/2001/WHO_MNC_CCH_01.01.pdf, accessed 22 June 2004).

WHO (2001b). *Men, ageing and health: achieving health across the life span*. Geneva, World Health Organization (WHO/NMH/NPH/01.2; http://whqlibdoc.who.int/hq/2001/WHO_NMH_NPH_01.2.pdf, accessed 22 June 2004).

WHO (2002a). *Active ageing: a policy framework.* Geneva, World Health Organization (WHO/NMH/NPH/02.8; http://whqlibdoc.who.int/hq/2002/WHO_NMH_NPH_02.8.pdf, accessed 22 June 2004).

WHO (2002b). *The world health report 2002: Reducing the risks, promoting healthy life.* Geneva, World Health Organization (http://whqlibdoc.who.int/whr/2002/WHR_2002.pdf, accessed 22 June 2004).

WHO (2003a). *Adolescent friendly health services: an agenda for change*. Geneva, World Health Organization (WHO/FCH/CAH/02.14; http://whqlibdoc.who.int/hq/2003/WHO_FCH_CAH_02.14.pdf, accessed 22 June 2004).

WHO (2003b). *Extending essential care: integrated management of adolescent and adult illness..* Geneva, World Health Organization (WHO/CDS/STB/2003.2; http://whqlibdoc.who.int/hq/2003/WHO_CDS_STB_2003.21.pdf, accessed 22 June 2004).

WHO (2003c). *Primary health care: a framework for future strategic directions.* Global report. Geneva, World Health Organization (WHO/MNC/OSD/03.01; http://www.who.int/chronic_conditions/primary_health_care/en/phc_report_oct03.pdf, accessed 22 June 2004).

Woodward CA, ed. (2000). *Strategies for assisting health workers to modify and improve skills: developing quality health care- a process of change*. Geneva, World Health Organization (Issues in Health Service Delivery Discussion Paper, No. 1; WHO/EIP/OSD/00.1; http://whqlibdoc.who.int/hq/2000/WHO_EIP_OSD_00.1.pdf, accessed 22 June 2004).

Annex I. Age-friendly Project Description and Summary of Focus Group Methodology

The project on developing Age-friendly Principles for Community-based PHC Centres had several phases. The first phase included secondary research, presentations at scientific conferences aimed at generating awareness of the project, identifying and inviting experts to join the Age-friendly Advisory Group meeting and identifying potential partners.

Next steps were the organization of focus groups of older people and health care providers in a sample of developed and developing countries which took place between June and September 2002. The focus groups examined knowledge, attitudes, barriers to community-based health care, and suggestions for rendering health care services more age-friendly. The findings of these focus groups and the background research informed the deliberations of an Age-friendly Advisory Group meeting convened to provide input and guide the project. The meeting took place in conjunction with the Sixth Global Conference on Ageing of the International Federation on Ageing (Perth, October 2002).

The outcome of the Age-friendly Advisory Group meeting was the Perth Framework for Age-friendly Primary Health Care. The Framework sets out the context, the overarching principles and the objectives of WHO's age-friendly project and summarizes the Guiding Principles for Age-friendly PHC centres. The document is reproduced in its entirety in Annex II on page 24.

Subsequently, research was conducted to compile a "toolkit" which contains:

- Practical, user-friendly clinical resources and references (e.g. pocket handbooks for geriatric medical care)
- Examples of protocols for assessment and management of common geriatric conditions (e.g. falls, incontinence)
- Examples of geriatric clinic charts and forms and checklists for assessment
- Age sensitization tools and exercises for all centre staff to increase awareness, knowledge and address attitudes towards older persons
- Examples of age-friendly management protocols (e.g. special queues for older persons)
- Guide to age-friendly educational materials development
- Concise guide to Principles of Universal Access to make centres accessible (e.g. door sizes, ramps)

The preliminary version of the tool-kit is being piloted and tested in selected PHC centres in a number of countries. Later phases of the project include possible modifications of the toolkit and its content, evaluation of quality improvement, and international implementation and dissemination strategies.

Summary of focus group methodology

The focus groups were run between July and September 2002 in five countries: Australia, Canada, Jamaica, Malaysia and in the Philippines. Two distinct series of focus groups were conducted. The first set, focusing on the users of PHC centres, was aimed at identifying potential barriers to accessing and receiving appropriate community-based care and gathering information on improving care.

Where possible, the focus groups were segmented by gender, age (50-65, 65+), socio-economic status (low, middle) and region (central, remote) in order to tease out any differences in attitudes and issues toward primary health care.

A second series of focus groups were run with PHC providers (i.e., nurses and doctors). Although it is recognised that the administrative staff of PHC centres also have a great deal of insight into what their clients view as barriers to accessing health care, the limited scope of these focus groups allowed for participation by clinical personnel (doctors and nurses) only.

The primary purpose of the provider focus groups was to identify provider attitudes toward older people seeking care, the scope of their PHC practice, and what they perceive as potential barriers for older people.

Moderators in each country were provided with a focus group procedure guide to ensure consistency across groups and sessions were audiotaped and transcribed. Key processes and findings were summarized in an overall report.

Annex II. The Perth Framework for Age-friendly Primary Health Care

Preamble/Rationale

The Madrid International Plan of Action on Ageing adopted by the Second UN World Assembly on Ageing (2002) emphasizes that health promotion activities, disease prevention throughout the life course and equal access of older persons to health care and services are the cornerstone of healthy ageing. It recommends measures to provide universal and equal access to community-based primary health care and to establish community health programmes for older persons. The Madrid Plan also calls for the elimination of discrimination in access to health care based on age or any other forms of discrimination.

WHO's Active Ageing Policy Framework, launched on the occasion of the 2002 World Assembly on Ageing, takes a life course and a determinants of health approach to ageing. In addition to an emphasis on health promotion, prevention and equitable access to PHC and long-term care, the Policy Framework stresses that health and social services need to be integrated, coordinated and cost-effective. There must be no age discrimination in the provision of services and service providers need to treat people of all ages with dignity and respect.

The United Nations Principles for Older Persons (1991) reaffirm the principles of independence, participation, care, self-fulfillment, and dignity, whereby older persons should have access to health care and should benefit from family and community care and protection, in accordance with each society's system of cultural values.

Every human being is entitled to the enjoyment of the highest attainable standard of physical and mental health conducive to living a life in dignity. The human right to health is recognized in numerous international instruments, among them the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, and the Constitution of the World Health Organization (WHO).

The process of rapid population ageing poses tremendous challenges to the provision of health care and social services and demands on such services may intensify as the number and proportions of older persons in populations continue to increase. The global disease profile is shifting from infectious to non-communicable and chronic diseases such as heart disease, stroke and cancer, many of which can be prevented or delayed through strategies which include health promotion and disease prevention. While the disease burden is rapidly shifting towards chronic conditions, health systems are still mostly geared to address acute, episodic events. But chronic diseases require ongoing monitor-

ing in order to minimize the development of associated disabilities and negative effects on the quality of life. Chronic care is often more effectively provided in a community-based rather than an acute care or institutional setting.

While older persons continue to enjoy relatively good health and are active contributors to their communities and families, many older persons require special attention and support in order to maintain health. Generally, older persons prefer to age in their own homes, within their communities or familiar environments. The proximity, accessibility, cost effectiveness and user-friendliness of community-based primary health care services are therefore of vital significance to the health and well-being of older persons and their families.

Community-based primary health care is generally the first point of contact with formal health services and is often complemented by social care. Health care provided at the community level should also include a range of health promotion and disease prevention activities. However, with a few exceptions, community-based primary health care services are often fragmented and are not sensitive to the needs of their older users. They may have inadequate resources and little emphasis on health promotion, prevention, systematic screening and referrals – all of which are essential for maintaining health of ageing populations.

Objectives

In an effort to promote the responsiveness of community-based health care to the needs of the population at large and in particular to the growing numbers of older persons, a set of General Principles Guiding Age-friendly Community-based Health Care has been developed. Such General Principles aim at providing guidance and setting standards in the provision of community-based health care to ensure that services are age-sensitive, age-responsive and more accessible to users of all ages and, in particular, older persons. Users of health care services, especially older users, must be empowered and enabled to remain active, productive and independent in their own communities for as long as possible. As an overall objective, the General Principles aim to enable older persons to achieve active ageing, defined by WHO as *the process of optimizing opportunities for health, participation and security in order to enhance the quality of life as people age.*

The General Principles target two major groups: (1) policy makers and professional associations, particularly in the health and social services sectors; and (2) health care providers at community levels, which include health professionals such as general practitioners, nurses, community health workers, as well as clerical health centre staff, family care-givers and social workers.

Beneficiaries of the General Principles will be health care users of all ages, in particular older persons.

It is expected that the General Principles, once put into effect, will result in the promotion of age-friendly attitudes and the provision of age-friendly health care services, especially at the community level. This will be achieved through increased

awareness and sensitivity to older persons and their needs, better training for service providers of health care for older persons, as well as better understanding and use of health care services by the users, i.e. older persons and their families.

The General Principles, once tested and implemented, will inform changes in attitude and practices at the community health care level. The implementation of the Principles should be monitored and evaluated regularly at the national and local levels by qualified professionals in collaboration with other stakeholders, to include in particular older persons. The implementation is to be governed by professional and ethical standards.

Overarching Principles

As an overarching principle, health care services must aim to provide the highest attainable standards of health, conducive to promoting active ageing and health over the life course and to maintaining life in dignity. Towards this end, health care services must meet the following essential criteria: Availability; accessibility; comprehensiveness; quality; efficiency; non-discrimination; and age-responsiveness. All medical services and attention should cover both physical and mental health, including the provision of equal and timely access to basic promotive, preventive, curative and rehabilitative health services and health education, regular screening programmes, appropriate treatment of illnesses and disabilities, preferably at the community level, as well as the provision of essential drugs. Further, health care services should be coordinated with the provision of social support services, including, when necessary, the provision of basic essentials such as food, shelter and safety.

Health care users of all ages, of which older persons are a growing target group, should be enabled to make informed choices regarding services available to them. The principle of non-discrimination should be upheld to ensure equal distribution and treatment, as well as the prevention of abuse, taking into account the economic, social, psychological and physical vulnerability of older persons.

The special health needs of women, particularly older women, must be taken into account in the promotion of age-friendly attitudes and provision of health care services. As older women generally account for the majority of the growing older population, community-based primary health care must ensure that attitudes, services and relevant policies integrate both age and gender concerns. Further, there is growing evidence that the health needs of ageing men are often neglected and need to be addressed by health care providers through special outreach programmes.

Age-friendly community-based primary health care must be responsive to cultural diversity, and sensitive to the concerns of all health care users, including older persons. The integration of cultural concerns and sensitivity into community health care provision will enhance the responsiveness of services and minimize barriers to service accessibility, thus empowering older persons, their families and community networks.

At the macro policy level, age-friendly community-based primary health care will help promote an integrated approach to public health and health care. The General Principles on Age-friendly Community-based PHC must therefore be fully integrated into relevant health and social policies at the national and local levels at all stages of policy making and implementation. For this process to be effective, cooperation and coordination between government departments, other relevant organizations and civil society as well as between the national and local levels must be improved. It is essential that investment in community-based health care, including health care of older persons and age-friendly community-based health care, be recognized as having long-term benefits and be supported by national governments, with adequate budget allocation and training support to professionals and informal caregivers. Ultimately, age-friendly community-based health care should result in attitudinal change, education, training and the whole range of integrated health services and social support to be comprehensive, accessible, responsive and cost-effective.

General Principles guiding the practice of Age-friendly Community-based PHC Centres:

It is recognized that the organisation and delivery of community-based primary health care services depend on national health care systems and their individual settings. However, the following General Principles are applicable to any community-based health care setting and provide guidance to all providers of formal community-based primary health services; such health care services include, among others, general practitioners, local health care centres, and community-based government clinics.

Age-friendly, Community-based PHC should incorporate the following General Principles:

1. In the areas of information, education, and training:

1.1 All health care centre staff should receive basic training in age, gender, and culturally sensitive practices that address knowledge, attitude and skills;

1.2 All clinical staff in the health care centre should receive basic training in core competencies of elder care;

1.3 Health care centres should provide age, gender and culturally appropriate education and information on health promotion, disease management and medications for older persons as well as their informal carers in order to promote empowerment for health;

1.4 Health care centre staff should review regularly the use of all medications, including complementary therapies such as traditional medicines and practices.

2. In the area of community-based health care management systems:

2.1 Health care centres should make every effort to adapt their administrative procedures to the special needs of older persons, including older persons with low educational levels or with cognitive impairments;

2.2 Health care centre systems should be cost sensitive in order to facilitate access to needed care by low-income persons;

2.3 Health care centres should adopt systems that support a continuum of care both within the community level and between the community and secondary and tertiary care levels;

2.4 Health centres should put into place mechanisms that facilitate and coordinate access to social and domiciliary care services;

2.5 All record keeping systems in health care centres should support continuity of care by keeping records on community-based, secondary and tertiary care as well as on the provision of social services for their clients;

2.6 All relevant stakeholders, including older persons, should be part of participatory decision-making mechanisms regarding the organisation of the community-based care services;

2.7 Information on the operation of the health care centre, such as opening hours, fee schedules, medication and investigation charges, and registration procedures should be provided in an age-appropriate way.

3. In the area of the physical environment:

3.1 The common principles of Universal Design should be applied to the physical environment of the health care facility whenever practical, affordable and possible;

3.2 Safe and affordable transport to the health care centre should be available for all, including older persons, whenever possible, by using a variety of community-based resources, including volunteers;

3.3 Simple and easily readable signage should be posted throughout the health care centre to facilitate orientation and personalise providers and services;

3.4 Key health care staff should be easily identifiable using name badges and name boards;

3.5 The health care facility should be equipped with good lighting, non-slip floor surfaces, stable furniture and clear walkways;

3.6 The health care centre facilities, including waiting areas, should be clean and comfortable throughout;

These General Principles can be adapted to each health care centre and provider setting in order to ensure responsiveness and sensitivity to the community served.

ANNEX III. Age-friendly Advisory Group

Scientific Advisors

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WHO wishes to acknowledge the many important contributions Professor Gerry Bennett made over the course of several years to the work of WHO's Ageing and Life Course programme. As a clinical practitioner and professor of Geriatric Medicine, he was deeply committed to improving community-based primary health care for older persons. His vision and commitment contributed greatly to the development of the Age-friendly Principles for Primary Health Care Centres. He believed that the implementation of Age-friendly Principles would bring us one step further to achieving the goal of accessible, comprehensive and equitable health care for all.

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