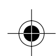

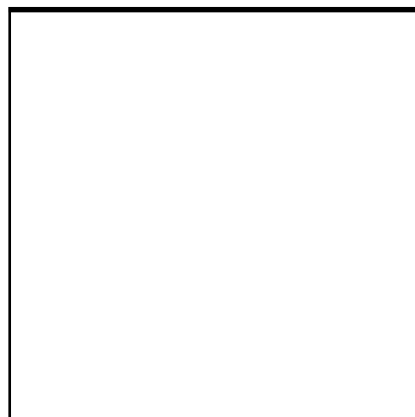

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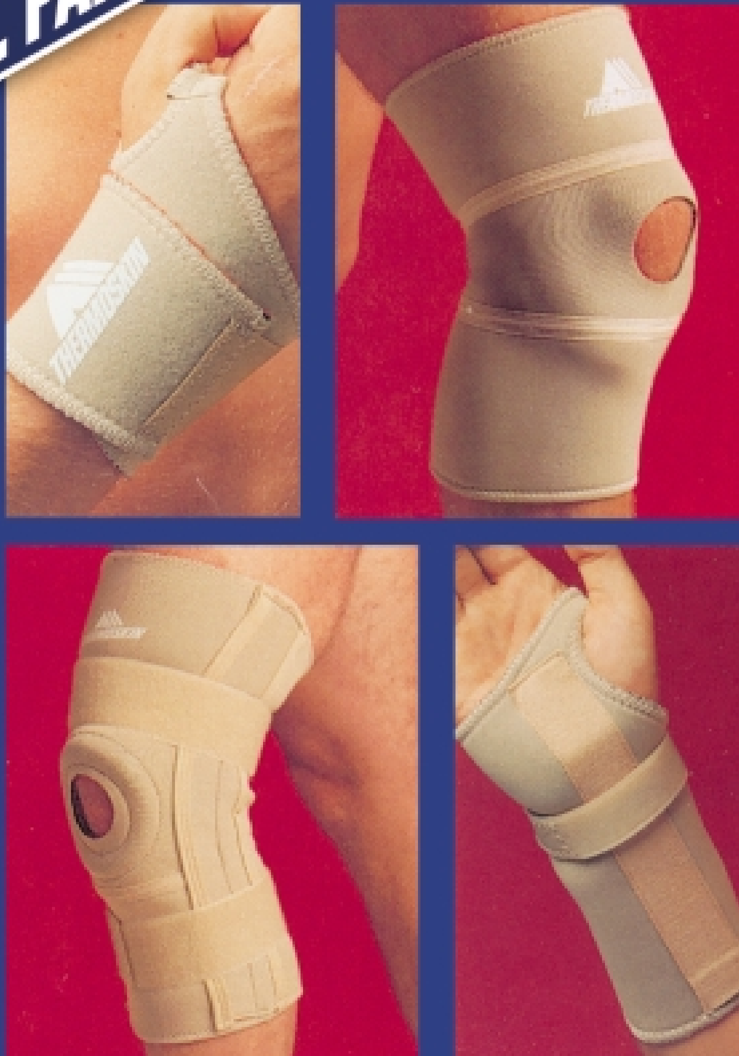

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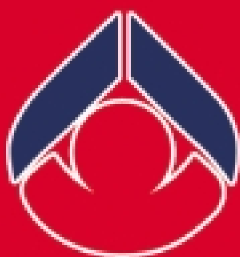

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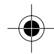

Rural Population Ageing in Developing Countries: Agricultural and Development problems

LIBOR STLOUKAL

Abstract

This paper demonstrates the role of rural population ageing in demographic and socioeconomic change and discusses its possible effects on sustainable rural development, with the aim of highlighting issues that are specifically relevant to professionals and institutions dealing with agriculture and rural development.

Demography of population ageing

At present, population ageing - the increase in the proportion of 'older people', i.e. persons aged 60 years and over, in the population- is much more advanced in Europe, North America and Japan than in the less developed countries of Asia, Africa and Latin Arnerica. The temptation might be to dismiss ageing as an issue that need not be addressed until some point in the future. To do so would be a mistake because:

• In the years to come, developing countrv populations will be undergoing unprecedented changes in their age composition (Table 1). While the proportion of the total population under 20 years will drop from its 2000 level of 43 per cent to 37 per cent in 2025, the proportion aged over 60 years will increase from 8 per cent to 14 per cent. By mid-century, developing countries will probably have an age structure similar to today's more developed regions.

• Populations of developing countries are still growing. However, in the coming years the overall tempo of population growth is predicted to slow down, but the growth in the over 60 age group is expected to increase (Figure 1). Thus, a period of more rapid ageing lies ahead.

• Population ageing is occurring much faster in developing countries than has been the case in Europe and North America. For example, while France took 11 5 years to increase the proportion of its older population from 7 to 14 per cent (WHO 2001), in many developing countries the same increase will be achieved in 20 years or less, and it will have happened by 2030 (UN 2003a).

• Developing countries are home to the majority of the world's older people. At present. about two thirds of the global number of persons aged over 60 years live in developing regions. By 2025 this proportion is likely to increase to 71 per cent (Figure 2).

• Not only will developing countries have less time to prepare for ageing, but most will have to face the ageing-related problems at much lower levels of development than the industrialized world. Many developing countries are already struggling to provide minimum levels of education, health care and income support for the needy. Population ageing in these countries will create adjustment pressures far more insistent than those experienced in Europe or North America.

Population ageing is a consequence of the continuing demographic transition, particularly the unprecedented decline in fertility levels experienced over the past 30 years. As a result, children and youths have come to represent a smaller proportion of the total population, while older people - the survivors of large birth cohorts - account for a greater proportion. This trend has been accelerated by marked falls in mortality rates and a transformation in both the age and cause structure of deaths - the

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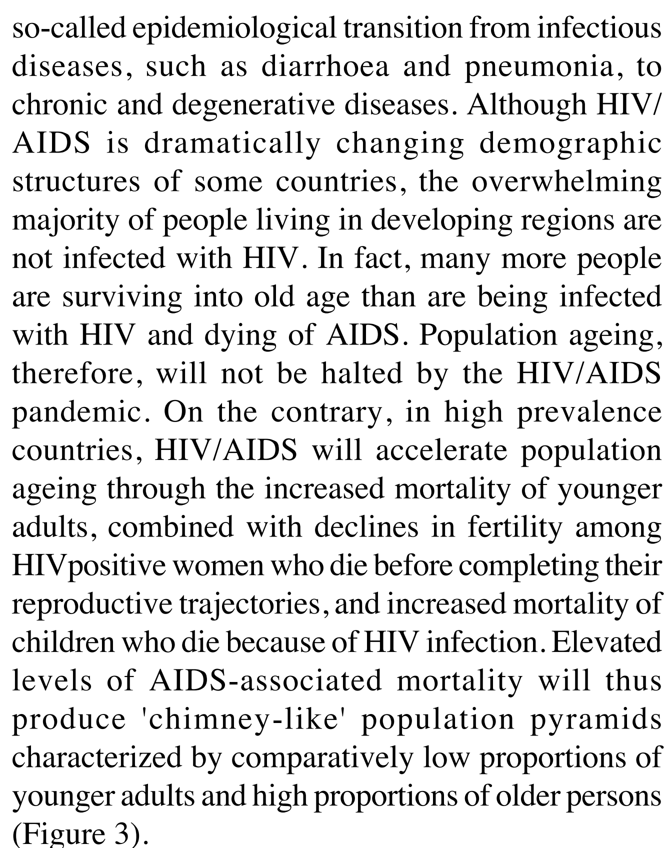

so-called epidemiological transition from infectious diseases, such as diarrhoea and pneumonia, to chronic and degenerative diseases. Although HIV/ AIDS is dramatically changing demographic structures of some countries, the overwhelming majority of people living in developing regions are not infected with HIV. In fact, many more people are surviving into old age than are being infected with HIV and dying of AIDS. Population ageing, therefore, will not be halted by the HIV/AIDS pandemic. On the contrary, in high prevalence countries, HIV/AIDS will accelerate population ageing through the increased mortality of younger adults, combined with declines in fertility among HIVpositive women who die before completing their reproductive trajectories, and increased mortality of children who die because of HIV infection. Elevated levels of AIDS-associated mortality will thus produce 'chimney-like' population pyramids characterized by comparatively low proportions of younger adults and high proportions of older persons (Figure 3).

The shift towards an older age structure has multiple consequences for population composition. The most important effects include:

- The greatest relative increases occur in the older segments of the old-age group, in particular the old-old (70+ years). Over time, population ageing leads to increased accumulation of particularly frail people suffering from age-associated physical and mental disabilities and dependencies.
- In virtually all countries women experience lower mortality levels than men. As a result, older women outnumber older men, hence the expression 'feminization of older life' .
- Another consequence of lower female mortality is the increasing proportion of older women who are widows living without the social and economic benefits of spousal support. Their situation can be particularly difficult if widowhood is associated with the loss of assets.
- Population ageing also causes changes in living arrangements, resulting in shifts in the household structure, particularly increases in the proportion of older people heading households or living alone. Because older people have usually lower incomes, population ageing increases vulnerability to poverty. As a consequence, the proportion of persons living below the poverty line can escalate, especially in the least developed countries.

The above considerations indicate that the global action on ageing needs to embrace developed as well as developing countries. However, it must be stressed that ageing in developing regions is characterized by vast regional and inter-country differences - which are not the focus of this paper - as well as variations related to factors such as socio-economic status, gender, and differences between rural and urban settings.

Rural dimension of population ageing

It is often assumed that in developing countries, ageing proceeds faster in urban areas where fertility and mortality declines are typically more advanced than in rural settings. In reality, ageing in rural communities usually manifests itself earlier and advances more rapidly than in the cities (Marcoux 1994, 2001; Skeldon 1999). By far the most important determinant is rural-to-urban migration which comprises mainly younger adults and thus increases the proportion of older persons 'left behind' in the villages. In some rural areas, ageing is further accelerated by factors such as the return of older persons, often upon retirement from the urban workforce, or the increased mortality among younger adults due to HIV/AIDS. Thus. in the majority of poorer countries, ageing is predominantly a rural phenomenon and it is in the villages where the consequences of ageing are most felt (Stloukal 2001).

Rural-to-urban migration has major implications for rural elderly people as many are left by their adult children, often with the responsibility for grandchildren. In these circumstances the productive opportunities for older men and women may become very limited, particularly if they are left to cultivate land that is beyond their physical capacity and have no possibility to hire labour, use animal power or mechanization. Rural outmigration, combined with

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falling fertility rates and increasing longevity, thereby increases the strain on older rural people, which can have negative consequences for their wellbeing as well as for their participation in rural development. Nevertheless, migration does open up opportunities for those migrants who are able to find paid employment, as well as for those rural residents who receive remittances.

Agriculture and older people

Older people fulfil multiple roles within the community, as workers, subsistence farmers, land owners, household members and breadwinners. Many are resourceful survivors and contribute to the well-being of their families and communities. However, research on the linkages between ageing and development in resource-poor countries (Heslop 1999, HAI 2002) has identified that the majority of older persons living in rural areas:

- have physical disabilities resulting from years of hardship and deprivation,
- are in poor health and experience high levels of anxiety and stress,
- are amongst the poorest in the community because of their diminished capacity to earn an income,
- are not covered by any pension scheme,
- are unable to access basic services: health care, potable water, energy, proper sanitation,
- live in physically demanding environments, but continue to work, often into very old age.

Most rural elderly do not retire from the labour force in the way urban workers do. Typically, their withdrawal from economic activities is gradual and is completed only when they become physically unable to work. Studies in Africa showed that, in 1993, between 74 per cent and 91 per cent of people over 65 continued to work, most in agriculture (HAI 1999). Some elderly persons, usually men, are able to continue in paid jobs, especially if they can shift to work which is less physically demanding. But most are likely to be doing home-based work such as farming. housework or childcare, often making essential contribution to household survival. The fact that older people are more likely to be involved in informal andlor part-time employment means that their work is generally under-reported in official surveys.

Environmental degradation, climate change and limited agricultural technology tend to affect older farmers more than their younger, healthier and better educated counterparts. This is compounded by discrimination against older people in accessing credit, training, and other income-generating resources. Processes such as diffusion of new agricultural technologies and introduction of improved seeds and tools often bypass older farmers as many have neither the spare cash to buy additional inputs, nor the skills (i.e. literacy) and energy to invest in adopting new practices. Because of gender divisions in agricultural production - with regard to opportunities to obtain credit and training, or participate in market exchanges - older women are particularly disadvantaged. Customary property practices, and in some settings even formal legislation, add to the discrimination faced by older women. For instance, in many parts of the developing world, women's direct access to land through purchase or inheritance is still limited (FAO 2003).

Rural population ageing inevitably leads to changes in the quantity and quality of agricultural labour force. It can be expected that in many areas the supply of agricultural labour will become increasingly tight as the relative numbers of those age-groups whose activity rates are highest will diminish due to the combined effects of migration to cities, fertility decline and, especially in African settings, increases in adult mortality rates because of HIV/AIDS. This means that there may be serious obstacles to expanding agricultural production, or even maintaining the existing production patterns, particularly if these depend on manual labour as is the case in most of Africa.

In addition to the effect on labour supply, increases in the proportion of older farmers whose physical and economic resources are often limited can have significant long-term consequences for agricultural communities, including:

- household livelihood strategies may become

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more subsistence-oriented,

- production options may evolve towards less labour-demanding activities, leading to reductions in cultivated area, declines in crop variety, or switches to less nutritious crops,
- intensity of measures with long gestation periods - e.g. soil and water conservation, use of fertilizers, construction and maintenance of irrigation systems, or tree planting may decline,
- the proportion of agricultural land available for rent or sale may increase,
- saving and investment behaviour may become more conservative,
- uptake of technological innovations may diminish.

So far, little research effort has been made to systematically asses the importance of these possible effects. However, the linkages seem to be intuitively plausible, and their implications for sustainable rural development might be indeed crucial. The sketchy evidence available indicates that, if socioeconomic circumstances are favourable, rural ageing can contribute to agricultural intensification - for instance by facilitating property transfers that lead to land consolidation and the creation of more economically rational holdings, as was the case in the Republic of Korea between 1980 and 1996 (Skeldon 1999).

Poverty in old age

In many developing countries, poverty is the key enemv of older people, with profound longterm impacts on their families and themselves. Many older people lack the basic requirements - food, water and shelter - and are chronically poor. Low levels of education, gender inequality and poor health are important determinants of poverty in old age. Social exclusion - the distancing of older people from their families and communities - can further separate older persons from sources of wealth. In its consequences, social exclusion can lead to outcomes that go beyond income and wealth into poor housing, malnutrition and personal insecurity (May 2003).

Poverty among the elderly differs from that of other categories of poor people for two principal reasons (Heslop and Gorman 2002):

- Old age is the late part of the human life span and as such it is associated with irreversible declines in physical capacity and adaptability to change. Consequently, relatively few old people can fully support themselves through existing earnings, and many have to depend on other sources: personal savings, family transfers, or community support. Social assistance programmes for older citizens are available in only a few developing countries - and where they exist, they are often less likely to reach rural areas.

- Traditional arrangements that guaranteed status and material well-being in old age such as the primary role of the elderly in kinship relationships, religious life, or property transactions - are often among the first ones to be eroded by socio-economic modernization. Changes such as the establishment of labour market mechanisms or land reform serve to undermine these traditional arrangements, forcing older persons into a marginal status.

Debates about poverty in old age usually concentrate on older women - because they live longer than men and face greater disadvantages and discrimination due to widowhood, lower social status and fewer opportunities to earn an income. However, given that their contribution is typically focused on family, household and informal sector work, older women may often be able to retain their social and economic roles longer than older men. By contrast, men are often seen mainly as economic providers, and the age-associated loss of earning power can significantly worsen their social status and self-respect. Privileges associated with being the family breadwinner and successful farmer in earlier years do not automatically transfer to older men. In addition, men may face considerable difficulties in shifting their activities into family and household-oriented functions, owing to lack of confidence or cultural barriers associated with performing 'women's work'. The consequences can be drastic. For instance, survey evidence from Africa shows that older men are more likely than older women to

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lose the support of their children and become beggars (Heslop and Gorman 2002).

Food insecurity of the elderly

Insufficient nutrition can be expected to be a frequent problem among older persons. Frail older people living alone appear most at risk from malnutrition because they may be unable to purchase, grow, or gather the food they need. Elderly living in households affected by HIV/AIDS are likely to be doubly vulnerable as the epidemic is decimating the middle generation of breadwinners, frequently reducing already poor families to extreme poverty. Even those older persons who live in well-off households may not get enough to eat, because of cultural practices or age-related abuse. During food shortages, older people are usually among the worst hit. In natural and political disasters, older people are frequently neglected and little effort is made to meet their needs for food, shelter, sanitation, health care or security (HAI 2001).

Not much empirical evidence is available about the nutritional status of older people in developing countries. For obvious demographic, epidemiological and political reasons, most research on nutrition among older people has, to date, been carried out in developed countries. The large survey databases that cover developing regions - WHO, UNICEF, Demographic and Health Surveys - tend to focus on children under five years of age and their mothers, without taking representative samples among other age groups. In addition, conventional anthropometric measurements of nutritional status are less applicable to older persons because of age-related changes in body composition.

The very few studies that do provide the required age-specific breakdown indicate that older people are often nutritionally vulnerable and frequently consume diets that are poor in both quality and quantity (Ismail 1999, FAO 2000, Dangour and Ismail 2003). Determinants of malnutrition in old age include a variety physiological, social and economic factors, ranging from lifetime exposure to diseases and poverty, to illiteracy, reduced social contact and poor functional ability (WHO 2001). Given the projected trends in ageing, the public health and socio-economic effects of this state of affairs are likely to be considerable. For instance, there is accumulating evidence that malnutrition in old age contributes to declines in immune function, morbidities such as bone fractures, and mental deterioration (Dangour and Ismail 2003). Increases in population ageing, if combined with old-age malnutrition, can thus worsen the health profile of rural communities, and hence their social and economic prospects as well.

It is important to note that the elderly can positively influence the nutritional status of coresiding relatives, particularly grandchildren. For instance, a recent study in rural Gambia demonstrated significantly improved nutritional status and survival among those children who had a living maternal grandmother (Sear et al.2000). This indicates that interventions to improve nutrition of the elderly, and thereby their health and ability to perform household tasks, can have beneficial effects extending far beyond the original target group.

HIV/AIDS and older persons

Demographically speaking, AIDS contributes to population ageing by killing younger adults and thus increasing the proportion of elderly in the population. The implication of HIV/AIDS for older persons is that they have to:

- bear the pain of losing adult children and other relatives,
- bear the loss of breadwinners, and thus the loss of support in old age,
- redirect their remaining energy and resources to care for the sick,
- deplete their resource base in quest for medical treatment and funerals,
- assist orphaned children, at a time when they themselves may need assistance,
- risk exposure to infectious diseases by being in close contact with sick household members,
- risk contracting HIV through sexual intercourse if they are sexually active.

HIV/AIDS has far-reaching economic, social and psychological effects on older people, destroying

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their hopes for the future and bringing new burdens as breadwinners and carers. The epidemic deepens poverty of people who are usually already poor. Collapse of household income, time spent caring for the sick, and the struggle to cover expenses such as drugs or burials can bring economic devastation. Of the African countries hardest hit by the epidemic, only South Africa and Namibia have old-age pension coverage, but even there pensions seem to be unable to alleviate poverty in households affected by HIV/AIDS (Legido-Quigley 2003). Evidence from Thailand shows that, although nearly 60 percent of elderly parents benefit from government health insurance in the payment of care and treatment cost for an ailing adult child, poor parents are far more likely than better offparents to suffer from financial hardship if a main household income provider dies (Knodel and Im-em 2003).

Widespread orphanhood also bodes badly for older persons in AIDS-affected countries, since grandparents often become surrogate guardians when parents are not able to raise their own children (Table 2). This role of the elderly is often associated with feelings of frustration as how to adequately cope with bringing up surviving orphans at a time when resources have dried up and other forms of support are no longer available (WHO 2002, HAI/IHAA 2003). The risk is that without external assistance, such as remittances or community support, many elderly will not be able to fulfil their considerable potential as carers of orphaned children, sources of agricultural and nutritional knowledge, and protectors of the rights of these vulnerable children to their land and other household assets (du Guerny 2002).

Challenges and opportunities of population ageing

While population ageing represents, in one important sense, a major success for human kind - a massive survival to old age has become possible - it also poses profound challenges to policies and public institutions that must adapt to changing age structures.

The principal challenge is associated with increases in the older population relative to the population of working ages (Table 3), which creates social and political pressures on social support and health care systems. These effects of population ageing can undermine sustainable development and economic growth, and burden already strained family and community support systems, as well as public institutions, national health budgets and other resources. Possible policy approaches to respond to these problems include (EWC 2002):

- policies to enhance traditional systems of family support,
- policies to encourage the elderly who are still capable to remain in the work force,
- institutions and systems to support high levels of personal saving to draw on in old age, and
- public programmed including pension schemes and national health care systems.

It needs to be pointed out that hitherto only a minority of developing countries have enacted policies on ageing. Many lack the necessary institutional basis, such as efficient pension and healthcare schemes, capital markets, and accounting or regulatory systems. A study conducted in 2002 revealed that out of 64 countries in Africa, Asia-Pacific and Latin America for which relevant data was available, only 24 had a national policy on older persons, although a further 16 were in the process of developing such a policy (HAI 2002). It is therefore not surprising that development policies for rural areas seldom recognize the needs of older members of rural communities.

However, population ageing has to be viewed as both a sustainable development challenge and an opportunity. On the positive side, in many countries the health status of older people of a given age is improving over time, because more recent generations have a lower disease load. Many older persons can thus live active lives until a much later age than in the past. If they are encouraged and assisted to be productive, they can be important economic contributors as well. Further benefits of ageing include the wealth of skills and experience that older people can bring to the workplace, to public life, families and households. In particular, rural elderly often have considerable knowledge in farming practices, in plants and their various uses

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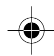

for nutritional and medicinal purposes. The elderly frequently act as guardians of traditions in farming and management of natural resources, many of which may be more ecologically sound than modern techniques (du Guerny 1997). In order to protect biodiversity, such knowledge must not be lost. Older people are also crucial in the inter-generational transmission of cultural identity and social cohesion. In AIDS-affected settings, they play a key role as carers of the sick and guardians of orphans. Furthermore, return migration of older persons to rural areas may represent a significant input for the rural economy in terms of human and financial capital (IOM 2001). The challenge for governments, therefore, is to move beyond traditional social protection approaches to invest in the productive capacities of older persons, in order to make the most of their potential for social benefit.

Implications for the agricultural sector

There is a growing recognition throughout the developing world that population ageing needs to be incorporated into national development strategies (HAI 2002). This is complicated by the fact that population ageing creates multiple problems for national economies, in particular for social support systems that must also satisfy the different needs of younger people. Governments will thus face increasingly difficult choices of how to use available funds without benefiting one group at the expense of others. Given the expected demographic dynamics, rural development in poorer countries will be increasingly dependent on older persons, and there is a growing need to adjust rural development policies to the realities of population ageing.

Population ageing is a global phenomenon that requires both national and international action. The UN system has developed a number of recommendations intended to assist countries in responding to the challenges and opportunities brought about by population ageing. Prominent among these is the Madrid International Plan of Action on Ageing (UN 2003b), adopted at the Second World Assembly on Ageing in April 2002. The Madrid Plan includes several recommendations that are directly relevant to institutions dealing with agriculture, food security and rural development:

- encouraging employment opportunities for all older persons who want to work (paragraph 28),
- improving living conditions and infrastructure in rural areas, including ensuring equal access to and control of economic resources by older rural women (paragraph 32),
- diminishing the marginalization of older persons in rural areas, with particular focus on empowering older rural women through access to financial and infrastructure services (paragraph 33),
- reducing poverty among older persons, particularly older women, the oldest old and other disadvantaged groups (paragraph 48),
- promoting access to food and adequate nutrition for all older men and women (paragraph 68).

The agricultural and rural sectors are undoubtedly in a strong position to assist in addressing ageing-related issues. Specifically, ministries of agriculture and other actors dealing with rural development issues could make a substantial contribution to the debate and action on population ageing by:

- examining the ageing-related issues from a holistic socioeconomic perspective, thereby contributing to the approaches focusing on social protection and health,
- promoting a better understanding of the implications of ageing for food security, labour supply, agricultural production, management of natural resources, transmission of agricultural knowledge, etc.
- mainstreaming the consideration of gender aspects of rural ageing into relevant development activities,
- developing rural development programmes and policies in ways sensitive to the needs and abilities of older persons.

It seems appropriate for experts and policy-makers in the agricultural/rural sector to intensify work on these issues because measures to establish appropriate responses require a considerable amount of lead-time. As stated in the Madrid International Plan of Action on Ageing, 'forward thinking calls us to embrace the potential of the ageing population as a basis for future development' (UN 2003b, p. 13)

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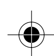
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Table 1: Projected Population aged 60 and above, selected major regions

Region		2000	2025	2050	Percent increase 2000-2025	Percent increase 2025-2050
Absolute number (in millions)						
Africa						
	Eastern Africa	11	21	48	85	130
	Middle Africa	4	8	18	75	131
	Northern Africa	11	27	60	140	123
	Southern Africa	3	5	6	79	14
	Western Africa	10	22	52	109	137
Asia						
	Eastern Asia*	136	305	446	124	46
	South-central Asia	105	232	458	121	98
	South-eastern Asia	37	87	172	132	98
	Western Asia	13	31	68	140	120
Latin America and the Caribbean						
	Caribbean	4	8	12	99	53
	Central America	9	23	50	155	114
	South America	29	68	123	136	82
Europe		147	198	222	34	12
Northern America		51	95	117	86	23
World total		606	1,180	1,907	95	62
Percentage						
Africa						
	Eastern Africa	4	5	8	11	59
	Middle Africa	5	4	7	-6	50
	Northern Africa	6	11	20	64	86
	Southern Africa	6	11	13	83	21
	Western Africa	5	6	9	20	64
Asia						
	Eastern Asia*	10	20	30	98	51
	South-central Asia	7	11	19	55	69
	South-eastern Asia	7	13	22	76	76
	Western Asia	7	10	17	52	67
Latin America and the Caribbean						
	Caribbean	10	17	25	68	49
	Central America	7	12	23	85	89
	South America	8	15	24	80	62
Europe		20	28	35	41	24
Northern America		16	24	26	49	8
World total		10	15	21	50	43

Note: Based on medium fertility variant projection. * excluding Japan.
Source: Elaboration of data from *UN 2003a*.

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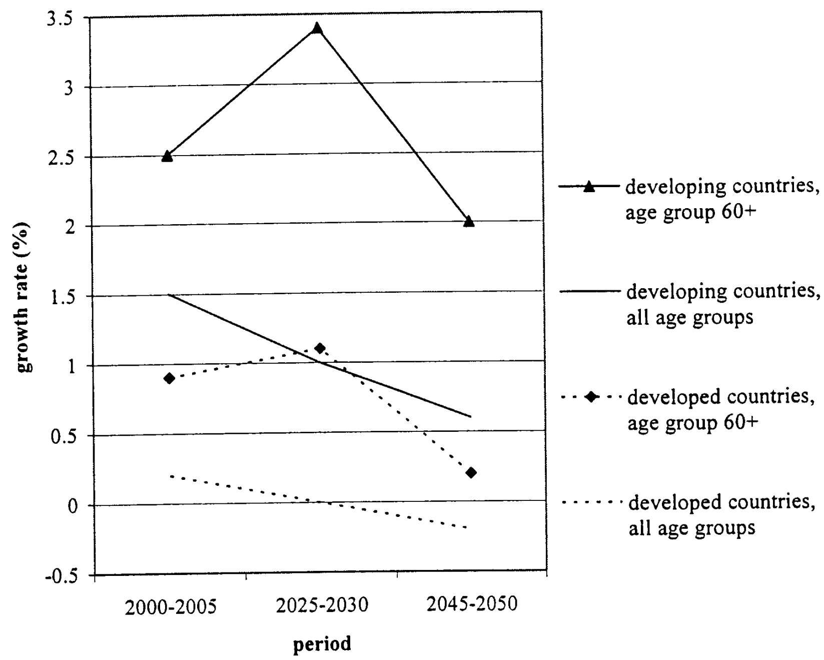
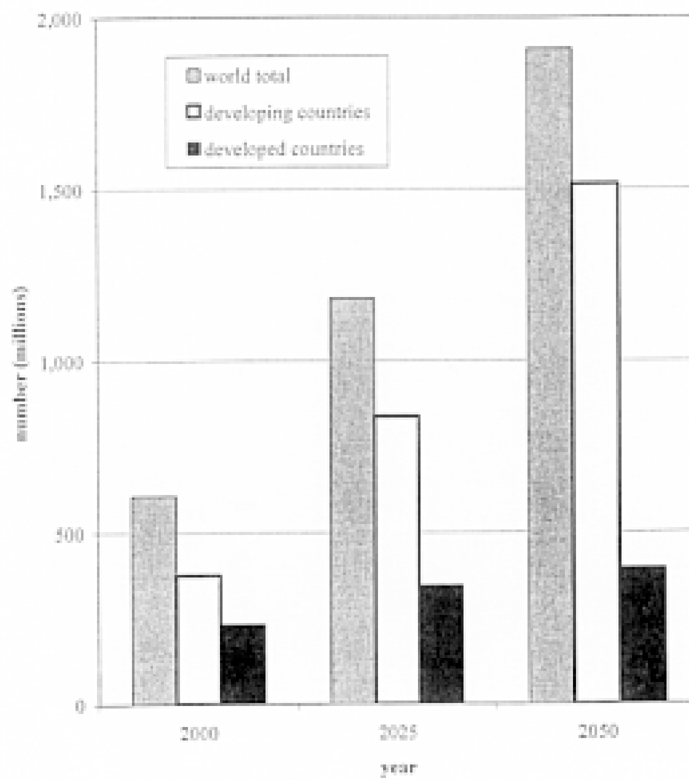
Figure 1: Projected population growth rates



Source: *UN 2002.*

Figure 2: Projected number of persons aged 60 and above



Source: *UN 2002.*

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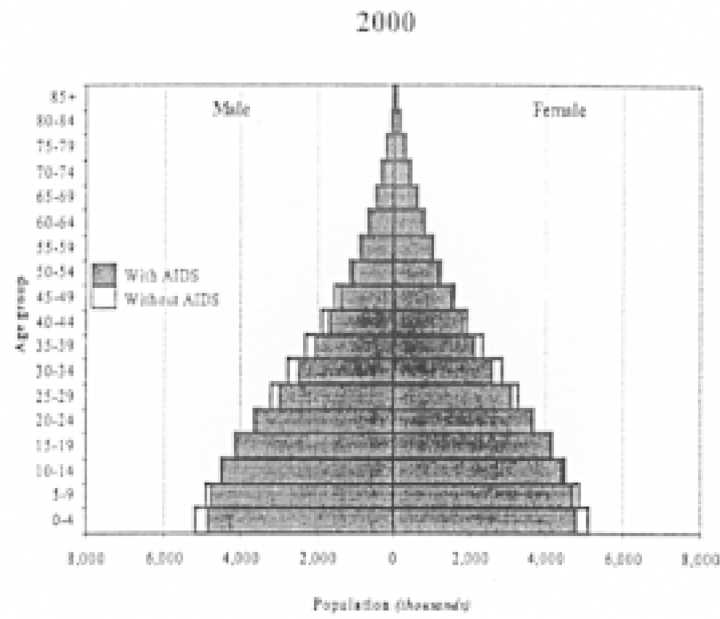
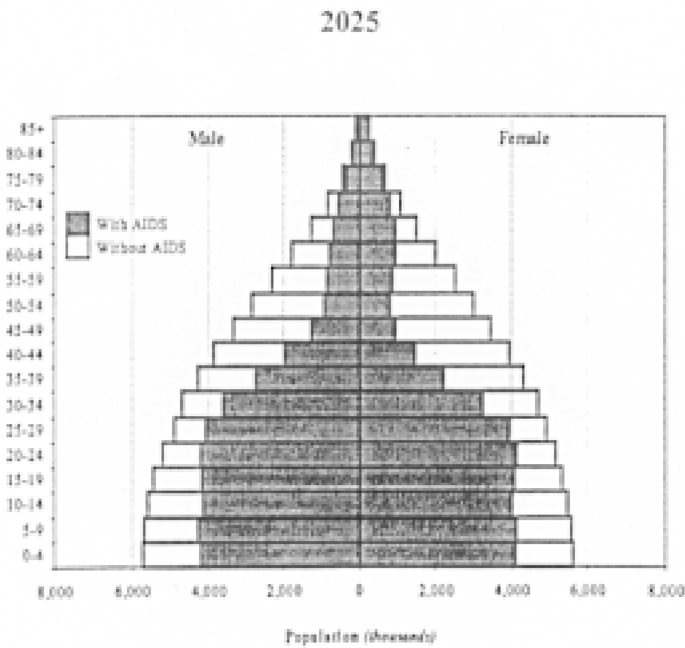
Figure 3: Population composition by sex and age in the medium variant ("with AIDS") and in the no-AIDS scenario ("without AIDS"), seven most highly affected countries in sub-Saharan Africa*

2000



2025



Note: * Botswana, Zimbabwe, Swaziland, Lesotho, Namibia, Zambia, South Africa.
Source: *UN 2003c*.

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Table 2: Who is caring for orphans?

Country, year	Sample covered	Carers	
Northern Uganda (1997)	2,119 orphans in Arua, Soroti and Lira districts	43 %	surviving parent
		16 %	uncles/aunts
		22 %	grandparents
		19 %	older orphans
		3 %	other relatives
Zambia (1996)	national survey	38 %	grandparents
		55 %	extended family
		11 %	older orphans
		6 %	non relatives
Uganda (2001)	732 orphans in Luweero district	32 %	grandparents
		50 %	surviving parent
		16 %	extended family
		5 %	non relatives
Rural Tanzania (2000)	297 orphans, Mawezi Regional Hospital	43 %	grandparents
		27 %	surviving parent
		15 %	extended family
		10 %	older orphans
		5 %	community

Note: Data are based on household surveys and so exclude children living in streets or residential care.
Source: *Ageing and Development*, Issue 15, October 2003.

Table 3: Projected old-age dependency ratios (aged 60+ per 100 aged 20-59), selected major regions

Region		2000	2025	2050
Africa				
	Eastern Africa	11	11	15
	Middle Africa	12	11	13
	Northern Africa	14	20	36
	Southern Africa	12	21	23
	Western Africa	12	12	17
Asia				
	Eastern Asia*	18	36	62
	South-Central Asia	15	20	34
	South-Eastern Asia	14	23	42
	Western Asia	14	20	32
Latin America and the Caribbean				
	Caribbean	20	32	51
	Central America	14	23	45
	South America	16	27	47
Europe		37	54	78
Northern America		29	48	52
World total		20	28	41

Note: Based on medium fertility variant projection. * excluding Japan.
Source: Elaboration of data from *UN 2003a*.

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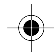

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AGING IN BRAZIL: Dependency and Family Care

CELIA F. CALDAS

Abstract

The twofold purpose of this paper is to draw attention to the phenomenon of "aging with dependency", a challenge that has not been adequately tackled by the Public Health system in Brazil; and also the responsibility of services for the elderly in providing the family with basic conditions to assume caring for them. The chosen themes in this analysis are dependency and ageing, the economic factor of dependency, family care and family needs. As it is a dynamic process, dependency needs to be dealt with through programmes, which range from health promotion strategies to the establishment of a supporting network and long-term care in the community. Although there is some initiative in this area in Brazil, it is not a coordinated effort. These programmes ought to be part of an effective public policy that involves all social units and can support dependent elderly persons, with or without family care.

Key words: ageing, dependency, family care, public policy.

Introduction

This study discusses the phenomenon of "aging with dependency" and the impact it causes on the family in Brazil. Although this subject is already recognized as an important public health problem in developed countries, in Brazil as in other developing countries, the authorities and society in general have not woken up to this reality.

The number of dependent elderly in Brazil is growing, since life expectancy is also growing. With the deficiency of social welfare provision, it has become evident that the family is progressively becoming the only source available for the care of dependent elderly persons, as seen in developed countries. Sundstrom, Johansson, & Hassing (2002) point out that recent cutbacks in services for the elderly in Sweden have undermined the mutual trust between individuals and the state. There are many indications that these changes lead to a new balance of responsibility for the elderly people. The same authors add that total spending on aged adults has stagnated, and institutional care is shrinking in absolute and relative terms in Sweden, but state financed home help for the elderly in the community is decreasing even more. Family members increasingly shoulder the bulk of care, but privately purchased care also seems to expand. Informal care is estimated to have provided 60% of all care to the elderly in the community in 1994 and 70% in 2000.

Despite the development of preventive medicine in the diagnosis and treatment of the diseases that cause dependency, the problem of increasing financial costs for the public or private health systems is intensified. The most important demographic change that will seriously influence the demands on public health services is the fast growth of the 85-year-old population. This age group generally presents a large load of chronic diseases and function limitations.

According to Hazzard et al (1994), the effects of advanced age itself are quite significant, the more so when added to some conditions that cause dependency, very common among the elderly, such as: dementia, hip fractures, cerebrovascular accidents, rheumatic diseases and vision impairments. These situations reduce the ability to overcome environmental challenges.

An example of the impact of these pathologies appears in reports of the consequences of dementia syndromes. According to Veras (1995), those syndromes are the main cause of incapability and dependency in the elderly. Brandt & Rich (1995), show that about 15% of the population older than 65 may develop dementia. For the elderly ageing 85 or over, the prevalence varies from 25% to 47%, depending on the education level (Baddeley, 1995, p. 243-244). Moragas (1994) adds that, despite the difficulty in diagnosing these pathologies, there is sense in recognizing that most of them are due to

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Alzheimer Disease. This disease is identified as the biggest problem for the Public Health system for the elderly in the future, because its consequences are still insufficiently perceived, due to lack of information, by professionals and by people in general. The author states that Alzheimer Disease affects more than 300.000 people in Spain and more than 4 million in the United States, where the cost of treatment reaches the sum of billions of dollars.

Not only in the dementia syndromes but also in relation to the majority of the diseases that cause dependency, there is generally no strong indication to institutionalize the elderly. Therefore, it is of great importance that the family and the community learn how to live, and deal, with such a reality: there is a great number of people depending on care.

However, there are some situations that do require the institutionalization of the elderly although these must be considered exceptions for instance, when other pathologies are included; when there is great difficulty in handling the patient; and when there is no support from the family or home care.

Dependency generates increasing expenses, which have an impact on the family economy. The patient's needs of permanent care impose high costs fomily, since no health system nowadays can cover enough services for a population with dependents in exponential growth. The economic relevance of expenses calls for a more accurate analysis, which would provide information from which health policy developers could draw objectives and actions towards a qualitative and economically possible solution to the problem.

On the other hand, investment in the health section sponsoring was suffering a reduction in relation to social expenditure in Brazil: in the sixties (Oiveira & Teixeira, 1995 in Sancho, 2001) when private capitalization was privileged. The same occurred in the seventies and eighties, as a result of the crisis caused by the fall of taxation due to the decrease in economic growth; and in the nineties when the crisis reached its highest summit, which extends to date, with the depreciation of health services because of the inefficient sponsor sharing among the three government bodies (Levcovitz, 1977 in Sancho, 2001).

The World Bank confirms this point of view when it "subordinates the expenses evaluation in health to the macroeconomics stability concerns in the countries on a structural process, " (Costa, 1996), or more specifically "demand detention by the reduction of public expenses, resources redistribution focusing profits in the commercial balance and policy reform in order to increase the long-term efficacy of economic systems" (id.ibid., 1996).

In Brazil, as in other developing countries, it is evident that there is no special public programme for the elderly with dependency, although there is actually a National Policy for the Health of the Elderly; this law was promulgated by decree in 1999. Researches, inquiries and studies, which seek to update and establish information about the problem, are relevant and may change into contributing sources for the sanitary policy makers, in both the public and private systems. The resources destination and the expenses partition for the agents involved needs to be discussed. The state, families and other agents yet need to have their roles mapped out.

This text is a critical review of the theme and intends to promote discussions that can lead to the support of the elderly and their families. The institution of policies, projects and actions is needed both in the public and private sectors, or by non-governmental organizations. As Mendes (2001) puts it:"*An increasing demand on health service for the age group that will mostly grow in this century and the existence of care alternatives put up important questions to those who make, plan, execute and, mainly, sponsor health services. To insist exclusively on the hospital and asylum model represents a complete disregard to what is happening all around the world, and disrespect for the elderly reality.* "

DEPENDENCY AND AGING

The word "dependency" relates to a fundamental concept in geriatric practice: "**fragility**". Hazzard et al. (1994) define fragility as the vulnerability

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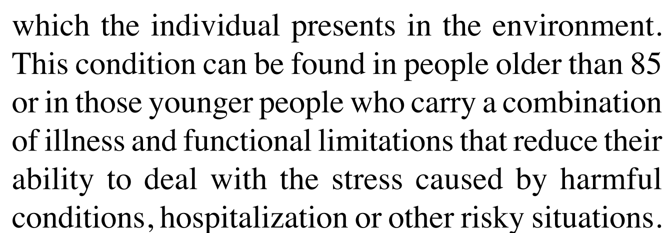

which the individual presents in the environment. This condition can be found in people older than 85 or in those younger people who carry a combination of illness and functional limitations that reduce their ability to deal with the stress caused by harmful conditions, hospitalization or other risky situations.

It is important to point out that, although most of these people may not show an organic disease or a change in physiological parameters at rest, quite old individuals can present deterioration under circumstances that can cause organic stress. Therefore, many elderly persons living independently in the community can suddenly become dependent when institutionalized because of pneumonia or other diseases.

When the theme is defined as "ageing with dependency", it brings up the question of chronic pathologies prevalence in that age group. Llera & Martin (1994) assert that this chronicity, observed in most of the elderly, requires special attention in order to be better evaluated, since chronic diseases may or may not cause incapacity. Hence it is necessary to classify the incapacity by dependency levels: slight, partial or total. Dependency levels are the main determinants of the types of care that are needed.

The functional evaluation is the method used to assess the levels of dependency. Widely known and applied to geriatric practice, this method is proving a sensitive and significant indicator used to evaluate needs and to determine the uses of resources. "Function" is defined as the ability that the individual has to adapt to everyday problems, in other words, those activities which involve the immediate environment around the person, including the role as an individual in a society, including whether the elderly person presents any physical, mental or social limitation. It is, therefore, a complex phenomenon influenced by many factors.

Dependency is expressed as indispensable aids for the basic achievements of life. It is not only incapacity that leads to dependency. Dependency is the sum of incapability and necessity. In other terms, dependency is not a permanent status, it is a dynamic process which through evolution can modify. It can even be prevented or reduced if there is proper environment and care.

The economic factor

Geriatric literature points out that when the elderly person is affected by a disease that causes incapacity, particularly from deterioration of neurological functions, causing dependency at a high level, it is common mainly in developing countries that care is provided as informal support. The system includes caregivers, who can be relatives, friends, neighbours and community members acting as volunteers.

The kind of attention the elderly need implies high costs for the family, since the public system does not offer enough resources. Economic costs of disease are due to two factors: on the one hand, the increasing need of care and attention, and, on the other hand, the caregiver frequently has to leave work to take care of the ailing, with income loss just when costs are rising.

Chappel (1993) reports that informal care is the most recent kind of approach in social attention provided by the community. Through contributions and help from family and friends, informal care is a cornerstone of the new rhetoric on care and support of the elderly. Informal care is more prevalent than formal care, even when an extensive health system is available. Family and friends are the main caring resource. The lack of informal support, and not disease, produces the greatest liability to long-term institutionalization. Chappell adds that, despite the evidence about the effectiveness of health promotion and the importance of community care and the general desire for elderly participation and integration in society, federal investment in the subject is still insufficient even in developed countries. Most investments still go to formal medical care.

Nowadays, the importance of long-term care in the community for the elderly population is well realised. Chappell declares that in industrialized countries community care is already integrated in the health system. In these countries it is also

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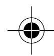

possible to observe that the expansion of care in the community is concomitant with studies and concerns about cost-efficacy.

According to Moragas (1994), public money alone cannot stand the costs to attend the needs of dependent patients throughout the years. Therefore, it is very difficult to plan the future, since there seems to be insufficient political interest and the technicians do not find any solutions. Full involvement on the part of the government, family, community, private sector, and so on is necessary.

Walker (1990), indicates that the impossibility to cope with the demand generated by the increasing elderly population can be used as the justification to transfer all responsibilities to the family and, this way, institutions that could properly support the elderly simply dispense some investment into the subject. Public policies in many countries officially recognize the contribution of informal care, volunteers and the private sector as a complement to the official public health role. Dependency still needs to be recognized as an important public health commitment. Its impact on families and society cannot be neglected.

Family care

The family remains as an essential resource for the informal support of the elderly. Kosberg (1992) mentions many reasons for family care having become the main source of elderly attention, considering the influence of historic tradition. The first reason is that family care is part of a culture. The family suffers social disapproval whenever tradition is not respected under the allegation of irresponsibility or negligence. On the other hand, there are the religious doctrines: most of the world's religions, if not all, sustain the notion that the responsibility towards the elderly belongs to the family. Although the elderly and the family relationship vary in every culture, most societies value the intergeneration interaction as one of the bases for the culture.

Even though the family care is an important aspect of culture, it does not apply for all the elderly. There are elderly people without a family. They may not have married, or be widowed or even have no children. Other elderly persons are so poor that the family cannot afford the proper attention. Others cannot afford to work part-time or quit a job to take care of the elderly. Yet another group are the elderly who lost contact with their families a long time ago.

Caldas (2002) indicates another reason why the family cannot be seen as the only support structure to elderly care: the quality of the relatives' relationship. Many references on the obligation to take care of their parents are based on a supposition of a good relationship between generations. It is clear that this supposition can easily be challenged by the conflicts and family disagreements as a consequence of incompatible personalities, values and life styles of the young and older people. However, although the elderly traditionally expect to be cared for by their children, and their children have no doubt about their responsibilities, these expectations have been changing. Certainly there are evidences of traditional responsibilities weakening as a consequence of urbanization. The greatest influence of urbanization is certainly the change from the big family structure to the nuclear one, which reduces responsibilities towards the elderly.

Many people do not want to depend on their children or other relatives. This is another important factor. It usually leads the family to take a long time to assume that they need to take the responsibility for their elderly relative's care.

Elderly people living alone is associated with a decrease of life quality, increase of morbidity, and even mortality risk. According to the Pesquisa Nacional de Nutricao e Saude—PNSN, 1989 (Nutrition and Health National Survey), more than 10% of the elderly population in Brazil lives alone, most of them are women and specially the 80 year-olds, or older, and 23% live in the countryside.

Anderson (1997) notes that, differently from North American and European countries, most of the Brazilian elderly live with their families. A great part of the population, mainly in the cities, lives in houses with few rooms. These houses are becoming

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smaller and smaller which implies bad conditions for elderly comfort and privacy.

Araujo & Alves (2000) show that the Pesquisa Nacional por Amostra de Domicilio— PNAD, 1996 (National Survey by Home Sample) describes more than 85% of Brazilian elderly as living in homes with relatives, and only a small part of them (11,6%) living alone or with non-relatives. Studies on intergeneration transfer have shown that, in contributing to the family support with their retirement pension, the elderly play an important role in the strategy for the family's survival. However, this does not mean that they receive the proper needed attention, for it is both an insufficient resource and a difficult task for the family to take care of them. Caldas (2002) asserts that an inadequate, inefficient, or even inexistent care is observed in situations in which the members of the family are not disposed to, are not ready to help, or even are overburdened by the responsibility. In this context, there is the actual possibility of perpetrating abuse and mistreatment. Therefore, although legislation and public policies affirm and society itself believes that the family must assist the elderly (for moral, economic or ethic reasons), this does not guarantee humanised care.

Traditional standards of family roles seem to be falling due to social, economic and demographic changes. As a result of this, cultural values have also changed in relation to the elderly themselves, in general, and to family care, in particular.

In order to follow the tide of these changes, programmes and services for the elderly are necessary. There is urgency for these resources, because many isolated, dependent and abandoned elderly need alternatives apart from the family care, and do not get it. On the other hand, many countries wonder whether alternative policies should recognise and reinforce the abandonment of family responsibilities. Nevertheless, one way the State can guarantee to citizens of all ages their social rights is to recognise the need of supporting structures for the elderly and their families and create them together with the local community, neighborhood, NGO's, private sector and religious institutions.

Family needs

Wikler & Hirschfeld (2003) point out long-term care for people with chronic illnesses and disabilities as an urgent challenge around the world. A recent WHO study estimates that in many developing countries the need will increase by as much as 400% in the coming decades. Existing systems of care, which typically rely on unpaid family members, are not by themselves enough to meet growing demands. Though families will continue to play a central role, the state must ensure that resources are available to address growing needs and ensure that those resources are distributed efficiently and equitably. A society invites a dialogue about how best to structure the ethical framework within which equitable, fair, rational, and transparent decisions about long-term care can be made when it asks: "What long-term care needs exist?" "What resources are available to provide them?" "What does justice require? The answers point the way towards systems that are responsible, accessible, efficient, and accountable, and that address the universe of human needs with dignity and respect.

Family needs can be expressed in three aspects: **material needs**, where finance resources and the subjects of residence, transport and health service access are included; **information needs**, concerning the pathology, the accomplishment of the care, the environment adaptation for the elderly; and **supporting needs**: including emotional support; the creation of a care network that joins the family and the supporting services, and also the need of a respite for the main caregivers.

Medeiros (1998) approaches a quite relevant aspect of the matter of financing the dependent elderly assistance: the transfer of the social security role to the families. Social benefits are the equivalent of payment for work when the person can no longer work, due to social or professional risk. In Brazil, the Social Welfare system assures this social protection. The same author mentions the Social Security definition: "... it is a social balance agent whose objective is to assure resources to support the individual and his family in case of risks or social circumstances, determined by death, incapacity, old age, disability, unemployment and imprisonment".

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The guarantee of this assurance is focused because there has been an increase in life expectancy due to a demographic transition, and consequently an enlargement of the number of beneficiary people, while contributions have not grown in the same proportion.

We can see that the Social Security System, whose objective is to guarantee health, welfare and social care (Constitution of 1988), is unable to fulfill its task, transferring the duty to the citizens and leaving to the families the role of covering its faults. In turn, the family, on lower Welfare benefits (retirement, pension or illness aid), can scarcely afford to buy medicines, and is outside of the expensive private health systems.

Even considering the difficulty of financing care for the dependent elderly in the community, it is possible to establish public policies which involve mechanisms of communitarian and institutional support to the families who take care of the elderly. Based on the data from her Doctor's Degree survey, Caldas (2000) concluded that, when the caregivers can count on a structure of institutional, strategic, material and emotional support, they can care for the alderly and remain socially inserted without being immobilized by the hard and stressful overburden of attention to the dependent patient.

However, there is a need for a better study on this subject. Bringing out the importance of such studies, Karsch (1998) points out that in developed countries, where there are conclusive studies on the costs of hospital assistance and institutionalization of people who had lost their functional capacity, community care programmes have proved cheaper alternatives to the health services, and they are generally based on raising formal and informal resources in districts or regions of big cities. For this purpose, studies are encouraged in order to establish who is taking care of the fragile elderly, who demand constant attention and follow-up measures after every hospital discharge.

When a family member descends into a process of dependency, the family's dynamics are changed. In relation to caregivers, Witmer (1990) affirms that there is a change in the role of the members of the family when a person develops disease. If the patient is one of the parents, the adult children take their parents' places and assume their responsibilities, becoming the caregivers, and will actually be overburdened with their own family responsibilities, and jobs.

Mendes (1995) points out that the decisions to assume caring duties are in a certain way spontaneous, and the studies reveal that, although the caregiver designation is informal and originates from an activity, the process seems to obey certain rules which arise from four factors: **Kinship** - partners are more frequent than children; **Gender** - women predominate; **Physical closeness** - involving the people who live with the patient; and **Affective closeness** - considering marital and parents/children relationships. But Mendes states that intra-family cares always drop on a family member. The family relationship itself produces the caregiver from the very moment one of the members is affected by a chronic-degenerative disease, causing dependency.

In general, women undertake the care and this role is assumed as natural, since it is socially foreseen in mother attributions, and women culturally carry out domestic duties. In this context, another significant variable appears: the caregiver's age group is the same as the patient's - they are "younger-old independent" taking care of the "old dependent".

According to Caldas (1995), the physical, emotional and socioeconomic overburden arising from family care is enormous. It cannot be expected to be proper care without the proper advice. Health professionals should teach the caregivers and supervise their activities. The family must also be prepared to deal with feelings such as blame, frustration, depression and others, which go with the care responsibilities.

Medeiros (1998) points out the results of a quality study on the caregiver's lifestyle in cases of extreme dependencies in the city of Sao Paulo, where a lower income population can reflect the lack of support and advice about care as in cities of other developing countries.

When the elderly person is discharged from hospital, the caregivers rarely receive clear information about

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the disease, neither any advice nor support about care, not even any instruction on how to continue the treatment. Most of them were superficialy informed about medication and return dates.

Neglect, lack of advice and lack of resources are present not only with hospital discharges,-but also in outpatient treatment. There is also a delay in getting a follow-up consultation with the doctor and a greater delay when a specialist, complementary examination, physiotherapy are needed. Many times the family does not get any information about the place where they can find treatment. Moreover, when they get the resource, they lack the proper transport to bring the patient to the doctor, due to the patient's physical limitations since many of them cannot even walk. A vicious circle is established: disease, lack of treatment, disease aggravation and a consequent increase in the expenses with the disease.

Felgar (1998) gives a study on home care: "the study of home support to adults with loss of independency and the profile of the main caregiver", a research coordinated by Ursula Karsch in Sao Paulo, between 1991 and 1995.Its main objective was to describe the characteristics of the community care available to adults with different levels of dependency, in a longitudinal perspective, in a metropolitan area of Brazil. The sample of 160 patients, who were discharged from various hospitals in Sào Paulo after being hospitalized for acute episodes of cerebrovascular accident, were visited three times a year. The data covered low-income families. On the subject of institutional support, the data indicates that more than 90% of caregivers did not receive any help from services, organizations, volontary groups or private agencies, and that obout 30% of them would have been pleased with such a service if they had got any. As for financial support, more than 90% of the caregivers complained that neither the patients nor themselves received any support from any institution.

Finally, referring to Karsch (1998), the dependent elderly person survives with few social and personal resources due to the current inefficient and precarious services of the Brazilian health system. In place of institutional attention, however, there are families, friends and religious groups; in other words, there is help which is not immediately evident but has to cope with daily difficulties, weaving the web of care, sometimes improvising, helping out those whose extremity of dependency demands the responsibility of someone else.

CONCLUSION

As Heslop & Gorman (2002) from HelpAge International, emphasise, a review of the actions of government, civil society and international agencies addressing the problem of old age poverty, indicates that Aging is still far from receiving adequate provision in development agendas at all levels.

Current poverty reduction measures and proposals have not sufficiently acknowledged the intergenerational dimension of poverty, nor has attention been paid to older people's own survival strategies. These are critical elements of any credible poverty reduction programme. On the other hand while the theme “aging with dependency” is being well studied in developed countries, in developing countries, the increase in aging population is a comparatively recent phenomenon and demands attention.

As a matter of fact, we have to deal with the social effects of the world economic crisis at the same time that the number of elderly persons is increasing. The economic recession brings deep social impact to the elderly in developing countries, especially to those who live with any kind of dependency; adjustment policies have contributed to intensify that impact by growing social inequalities.

Even though the law grants victory in the battle fo the elderly poor for social welfare allowances, the dependent elderly problem has not been solved since high employment levels keep family income below the poverty line.

The dependency of an elderly member of the family generates an impact on the family's dynamics, on the family's economy and on the caregiver's health. Moreover, it is necessary to think of those elderly

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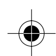

with no family to provide support in dependency situations.

Although in Brazil, the Constitution, the Elderly National Policy and the National Policy for the Health of the Elderly indicate the family as responsible for the elderly, both an aid system for the family and the definition of formal and informal care responsibilities has not been properly established up to now. The public or private health system is not adequate to serve either the ever increasing elderly demand, nor their families. Neither the public nor the private Social Welfare system foresee financing procedures for networks to support the dependent elderly, with or without a family.

Dependency must be seen as a dynamic process. Its development can be prevented if there is the proper assistance and environment. Therefore, the solution for aging with dependency problems relies on such a policy that includes not only the government, but also all sectors of society, and yet runs programmes to prevent the independent elderly person from falling into dependency.

A Family Health Programme can be an efficient strategy to deal with this challenge, but it would have to incorporate the care of the elderly with dependency as a specific matter, which includes financing the actions and establishing an institutional support network. Non professional caregivers could and should be seen as health agents and receive advice towards the proper care for the elderly, including preventive action to avoid early dependency, and special care for the dependent elderly.

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IS AGEING A DISEASE?

SUSANA WORTMAN

On analysing the history of medicine, Michel Foucault states that, in the past, what society demanded from the medical profession was to provide strong healthy people capable of working – emphasis was in securing a contiued labour force. Today, medicine relates to the ecoomy through consumerism: health is a product that can be manufactured by laboratories and physicians, and consumed by the supposedly and actually infirm. The same author notes that education shapes the standard of living twice as much as medical drug consumtion. Thus, in order to promote a longer life it is preferable to have a higher level of education rather than hiegher medicine consumption. It has been demonstrated that the levels of medicine consumption of substitutes and additives and the pharmaceutical market proposees to recover the lost wellness, sleep, memory and energy, and to stop 'ageing'. Sometimes the virtues of these substances extolled by university graduates or TV, and in this way a fetish is legitimised and 'pharamacophilia' is installed in the public.

Biomedicalization of the ageing process implies its social interpretationa as a medical problem, and it promotes practices and policies accordingly. This model, which is hegemonic in medicine, is supported by a system of beliefs that is adapted by the family and friends of the ageing person. There is a firm conviction that the consumption of increasingly costly medical services and technology can solve the environmental, social and economic problems involved in the etiology of most illnesses.
A marked inability of the population to endure suffering is also noted, which puts pressure on the physician to solve the problem through prescription drugs. The elderly are not always conscious of the emotional factors involved in the etiology of most illnesses.

A marked inability of the population to endure suffering is also noted, which puts pressure of the physician to solve the problem through prescription drugs. The elderly are not always conscious of the emotional factors involved in their physical symptoms. This is compounded by the attitude of physicians, who often have no time to listen to them and wrap up their visit by quickly writing a prescription.

Medicalization leads individuals to lose their ability to become properly aware of their condition and to confront certain events by themselves, as in the case of normal bereavement, where, when the chosen option is prescribing drugs, sadness is confused with depression.

Hayde' Andres ("Uso racional de psicofarmacos en psicogeriatria' "The rational use of psychoactive drugs in psychogeriatris," in Revista Argentina de Geriatria y Geronologia, No. !5, 1995) notes that the normal manifestations of health are often interpreted by medical staff as symptoms of illness. Thus, when an old man cries, this is often labelled as "incontinence", "emotional lability" and even applied without listening to the patient – listening being a practice that should not be restriced to psychotherapy. Following the notion according to which disease is something "out there", an evil of which the patient is a victim and of which he must be liberated, physician and patient strike a relationship that organizes itself around that "something" that one is ill with and the other acts upon, but which, essentially, may be foreign to both. It is important that the physician can give his ear to the offer of symptoms made by the patient without excluding in advance any channel of expression – be it somatic, mental, familial or social – and to include the patient in the dynamic field so structured.
Often the elderly seek medical help looking for support, they see the physician as their only chance for protection when they have not been able to overcome their separation, or when their families and the community networks have responded with indiffernce or marginalization. Thus they strike with "their" doctor a relationship of dependence; they

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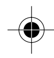

position themselves as subodinates and as subjects of overprotection. If the physician accepts this condtion – or if he imposes it – asymmetric relationship is thus generated, with decisions made only by the medical professinal which in turn favour the process of medicalization.

Cummings and Henry (cited by L. Salvarezza in Psicogeriatria. Teoria y Clinica/Pstcgigeruatrics. Theory and Practice, Paidois, 1996) developed the "theory of detachment," according to which ageing individuals progressively detach themselves from all kinds of social interaction and consider this process to be normal, universal, inevitable and intrinsic. This theory continues to consciously and unconsciously encourage the attitude of medical professionals, family and friends toward the elderly, who regard the progressive detachment of their activities as a normal stage in anticipation of death. From this theory arises the idea that old people lack sexuality, and in case they express a sexual desire this regarded as abnormal.

This prejudice is remarkably ingrained in the mind of both pyhsicians and society at large, and can be traced to viejismo (ageism), a concept introduced among us be Leopoldo Salvarezza: the ageing person faces social discrimination and devaluing, which are the results of a cultural model that defines old age as a stage of physical and mental decay. This prejudice makes old age to be regarded as something that's 'out there' as opposed to within ourselves, thus preventing us to anticipate (and therfore be prepared for) our own ageing.

Physicians who have been forewarned about these issues will likely take into account aspects such as the elderlyp person's sexuality, his food preferences, habits, physical activity and interests. Before prescribing a psychoactive drug to fight insomnia doctors should try and find out what the elderly person's day is like, how he uses his time,whether he does something to obtain pleasure, if he has friends, what his family circle is like, etc.

The intra-psychic processing of changes at old age depends on the ability to modify the patient's aspirations: a bereavement process takes place. But then another possible reaction in narcissistic withdrawal: the subject isolates himself and rejects all possibility of investment (expanding psychic energy), which facilitates the emergence of somatic symptoms. According to Fishbein ("Los procesos somáticos en la vejez" / "Somatic processes in old age" in *El envejecimiento*. Psiquis, poder y tiempo, Eudeba, 2001), "The narcissistic regression which the injury of devay of enery leads to, takes shape as an object, and intensifies concerns about it." The body is an object of attention and gazing, but such gazing have to do with disease rather than with eroticism: "it becomes a body of necessities rahter than the seat of desire."

However, when this self-absorption becomes reminiscent, an adequate ageing process may be promoted. According to Graciela Zarebski (*Hacia un buen envejecer*, Emecè, 1999), it's about "linking past, present and future, re-writing one's own history, attaching new meanings to it from a present that, despite less productive and reproductive work and less energy to carry them out, turns out to be bolstered inasmuch as it is mental work whose result is an incessant renewal of the representational field."
Accepting old age requires maintaining an alliance with the previous generation, and at the same time opening way to the new one.
Finally, it is clear that the lack of family support, isolation, lack of projects and the absence of social nets all contribute to reinforcing medicalization of the elderly.

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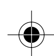

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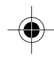

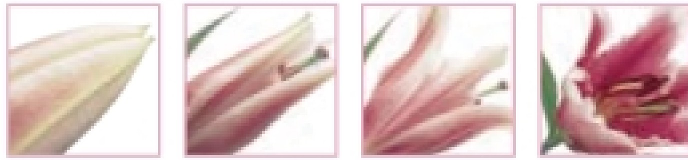

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Abbreviated Prescribing Information
'ARIMIDEX' (Anastrozole)
See local Prescribing Information for full details, as Prescribing Information may vary from country to country.
Presentation: Film-coated tablets containing 1 mg of anastrozole.
Indication: Adjuvant treatment of post-menopausal women with oestrogen receptor-positive early invasive breast cancer who are unable to take tamoxifen therapy because of high risk of thromboembolism or endometrial abnormalities.
Treatment of advanced breast cancer in post-menopausal women. Efficacy has not been demonstrated in oestrogen receptor-negative patients unless they had a previous positive clinical response to tamoxifen.
Dosage: 1 mg orally once a day. For early disease, recommended duration of treatment is 5 years.
Contraindications: Pre-menopausal, pregnant or lactating women, patients with severe renal impairment, patients with moderate or severe hepatic disease and patients with hypersensitivity to anastrozole or any excipients. Co-administration with oestrogen-containing therapies or tamoxifen.
Warnings and Precautions: Not recommended for use in children. Menopause should be defined biochemically where doubt about hormonal status. Care in driving or operating machinery. No data to support safety in patients with moderate or severe hepatic impairment or severe renal function impairment. No information on use in combination with LHRH analogues or other anti-cancer agents.
Women with, or at risk of osteoporosis should have bone mineral density assessed and should be monitored carefully.
Pregnancy and Lactation: 'Arimidex' is contraindicated in pregnant or lactating women.
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Interactions: Oestrogen-containing therapies or tamoxifen should not be co-administered.
Further information is available on request from AstraZeneca or local AstraZeneca subsidiaries.
'Arimidex' is a registered trademark owned by the AstraZeneca group of companies.
Revised: December 2002
Based on Package leaflet Text No: 11 JJB J000-107-912.2.0
Indications not registered in all countries.

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Pulsar 5103/March 2003

FIFTH MEETING OF THE INTERNATIONAL BOARD OF INIA MALTA, 5 - 6 MAY 2004

The Fifth Meeting of the Board Members of the International Institute on Ageing, United Nations Malta took place between the 5 - 6 May 2004 at INIA's premises in Valletta.

The Meeting was chaired by the Chairman of the Board, Dr. Jose Antonio Ocampo, Under Secretary-General, Department of Economic and Social Affairs, United Nations, New York. The Board Members present were: Prof. Gary Andrews, Director, Centre for Ageing Studies, Flinders University, Adelaide, Australia; Dr. Sharod Gokhale, President, Community Aid and Sponsorship Programme (CASP), Pune, India; Prof. Gloria Gutman, Professor and Director Gerontology Research Centre, Simon Fraser University, Vancouver, Canada; H.E. Dr. Ugo Mifsud Bonnici, Former President of Malta; Rev. Prof. Peter Serracino Inglott, Former Rector of the University of Malta; and Prof. Zhang Zhixin, Vice-President of the China National Committee on Ageing (CNCA) who was substituting Mr. Li Baoku, President of CNCA. Dr. Dalmer Hoskins, Secretary-General of the International Social Security Association (ISSA), Geneva, Switzerland and Prof. Robert Butler, President and CEO of the International Longevity Centre (ILC), New York, U.S.A. were unable to attend due to other commitments. INIA staff in attendance were Prof. Frederick F. Fenech, Director, Prof. Joseph Troisi, Deputy Director (Rapporteur) and Mr. Joseph Micallef, Administrator.

Dr. Ocampo commented on the outcome of the Second World Assembly on Ageing, which was held in Madrid in April 2002 and remarked that the United Nations system had to rely on a network of agencies, one of which is INIA, in order to implement the priorities, issues and objectives of the Madrid International Plan of Action on Ageing. He stated that during the short time at his new position as Head of the Department of Economic and Social Affairs at the UN, he has become quite aware of INIA's work and emphasized on the important role which INIA has to play in order to implement the Plan of Action through its training programmes and capacity building in developing countries. He emphasized on the importance for INIA to multiply its activities and for DESA and INIA to work closely together in preparing countries to meet the challenges of population ageing through the training of personnel.

The Agenda and the minutes of the previous Board Meeting held in Madrid in April 2002 were approved.

Prof. Fenech, Director of INIA, welcomed the Board Members and reported on the activities of the Institute for the years 2002 and 2003. He covered INIA's activities under the headings of Training, Networking, Research, Publications and International Activities. He outlined the Training Programmes, which were regularly updated, in Malta which trained 1561 participants from 128 different countries. He remarked on the increased demands for in-situ programmes and more satellite centres were being set up to increase the capacity building of trained personnel in the field of Ageing. He thanked the Government of Malta for the annual contribution to the Institute which helps to cover the administration costs of running the Institute. UNFPA continued to be the main funding sponsor of the training programmes and for this, INIA is very grateful. Most welcome funding support for the training activities has been forthcoming from the Merck Institute on Aging and Health, Washington, USA. He reported on the strengthening of the Network with past participants as well as research and the publications BOLD which is now posted on the re-designed and upgraded Website and whose articles can be downloaded. He commented very favourably on the cooperation with the University of Malta, especially its European Centre for Gerontology and Geriatrics. He reported that INIA hosted in November 2003 an Expert Group Meeting in the Modalities for Review and Appraisal of the Madrid International Plan of Action on Ageing organized by DESA. He also reported on the

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International Conferences related to Ageing attended by INIA staff and the participation of the Deputy Director of INIA as a member of the Task Force to monitor the implementation of the Regional Strategy for Europe.

The Work Programme for 2004 to 2006 was then presented. This included the core programmes as well as a yearly workshop in Malta. Applications for these programmes far outstripped the available places. On an average 5 in-situ programmes will be held every year. An important activity for this period is the joint study being undertaken by INIA and UNFPA to audit the effectiveness of INIA's programmed Prof. Fenech finished his report by stating that INIA will continue to take part in various activities in the field of Ageing organized by UN agencies and other affiliated international organizations. He thanked the Government of Malta, UNFPA, the Merck Foundation for their support and thanked all the Board Members especially those from overseas for travelling so far to attend the Board Meeting. He looked forward for their support during the next three years.

The report of the Director and the programme proposed for 2004 - 2006 were then open for discussion. All Board Members participated. They commented very favourably on the costeffectiveness of INIA's programmed The issues discussed included the need to have in-situ programmes also in Latin America and Middle East, to have workshops on other topics such as spirituality, the need to establish a programme in distance learning and the efforts by Board Members to identify other possible funding sources.

The Director's Report and Programme for 2004 - 2006 were approved. Dr. Ocampo, then, closed the Meeting by stressing the importance of INIA's central role in the field of Ageing. He augured that INIA, through the activities, will help meet the challenges of population ageing in the world, a phenomenon with no precedent.

Fifth Meeting of the Board members held at INIA's premises in Valletta, seated from left to right are: Dr. Jose Antonio Ocampo; Dr. Sharod Gakhale, H.E. Dr. Ugo Mifsud Bonnici; Rev. Prof. Peter Serracino Inglott; Ms Su Jinghua; Prof.Zhang Zhixin; Prof. Gloria Gutman; Prof. Gary Andrews; Prof. Frederick Fenech.

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MERCK INSTITUTE FELLOWSHIPS

The International Institute on Ageing, United Nations – Malta has received a grant from the Merck Insitute of Ageing and Health, Washington D. C. for the years 2003 and 2004 for Training Programmes, which are held in Malta. These funds support the educational activities of 8 Fellows from developing countries participating in the Short Taining Programmes in Social Gerontology, Economic and Financial Aspects of Ageing, Geriatrics and Demographic Aspects of Ageing as well as 2 Diplomates participating in the 9-month Postgraduate Diploma Course in Gerontology and Geriatrics at the European Centre for Gerontology, University of Malta.

Applications for the above Fellowships will be received by Professor Frederick F. Fenech, Director of the International Institute on Ageing,United Nations – Malta, 117, St. Paul Street, Valletta VLT 07, Malta, e-mail **ffen@inia.org.mt.**

The closing date of applications can be obtained from the Institute's website, **www.inia.org.mt.**

A Society for All ages

The 7th International Federation on Ageing (IFA) Global Conference 5-8 September 2004, Singapore

Hosted by Singapore Action Group of Elders (SAGE)

Conference Theme : "Global Ageing: Sustaining Development"

In April 2002, there was an unprecedented collective effort by UN member countries and NGOs to address ageing issues. The United Nations 2nd World Assembly on Ageing, First World NGO Forum and the Valencia Forum were held in Madrid and Valencia, Spain. Action plans were drawn up for countries to implement. 2 and a half years later, in 2004, the 7th IFA Global Conference in Singapore will be an ideal platform to share your research findings, programmes and services to advance the couse of seniors with an international audience.

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INTERNATIONAL DIARY 2004

2004
SEPTEMBER 5 - 8 SINGAPORE
International Federation on Ageing 7th Global Conference – Global Ageing: Sustaining Development.
Information: Website: www.7ifaconference.com

SEPTEMBER 10 - 11 – LONDON, U.K.
Anti-Ageing Conference
www.antiageingconference.com

SEPTEMBER 12 - 18 BEIJING, CHINA
International Social Security Association (ISSA)
28th General Assembly

OCTOBER 3 - 5 MONTREÀL, QUÈBEC
International Conference toward a New Perspective: from ageing to ageing
Information: www.qeri.duke.edu/busse/busse.html

OCTOBER 15 - 17 – KYOTO, JAPAN
International Conference on Alzheimer Disease "Dementia Care in an Ageing Society"
Information: Website: www.alzheimer.or.jp.

DECEMBER 2 - 3 – CARDIFF, U.K.
Final Scientific Conference on Dignity and Older Europeans
Information: E-mail: doe-project@cf.ac.uk

2005
FEBRUARY 9 - 18 NEW YORK, USA
43th Session - Commission for Social Development

JUNE 26 - 30 – RIO DE JANEIRO, BRAZIL
World Congress of Gerontology (IAG)

NOVEMBER 17 - 20 – THESSALONIKI, GREECE
2nd International Congress on Brain and Behaviour
Information: www.psychiatry.gr

INIA'S ACTIVITIES 2004

5th – 8th September	International Federation on Ageing (IFA) 7th Global Conference, **'Global Ageing: Sustaining Development'**, (SINGAPORE)
6th – 17th September	International Short Training Programme in **Demographic Aspects of Population Ageing and its Implications for Socio-Economic, Policies and Plans**, (MALTA).
25th Sept – 4th October	Training Programme in Gerontology in collaboration with the Beijing Civil Affairs Bureau (BCAB), Beijing, (MALTA)
Oct. 2004 – June 2005	International **Post Graduate Diploma in Gerontology and Geriatrics (Dip.Ger)** European Centre of Gerontology and Geriatrics, (University of Malta), (MALTA).
10th – 18th October	Short Training Programme in **Social and Health Aspects of Ageing** in collaboration with the Beijing Civil Affaris Bureau (BCAB), Beijing, (MALTA)
13th – 16th October	Conference on **"Medicines Management in Older Persons"** organised by the International Institute on Ageing - United Nations, (Malta), in association with the University of Malta – Department of Pharmacy, Zammit Clapp Hospital for the Aged, Parliamentary Secretariat for the Care of the Elderly – Ministry of Social Policy and the European Society of Clinical Pharmacy, SIG Geriatrics, (MALTA)
30th October – 5th November	In-Situ Training Programme in **Gerontology** in collaboration with the Beijing Civil Affairs Bureau (BCAB), Beijing, (CHINA).
6th – 17th December	In-Situ Training Programme in **Gerontology** in collaboration with the Singapore Action Group of Elders (SAGE). (SINGAPORE)

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