The 2013 Brazilian Longevity Forums: Developing a Culture of Care in Response to the Longevity Revolution

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Within the current century (1950-2050) there will be a 26-fold worldwide increase in the number of people aged 80 and above (from 14 million to 379 million) making them the fastest growing population sub group.
Despite the fact that ever-increasing numbers of them will continue to live active lives, significant numbers will experience disabling conditions and frailty that require ongoing care. Smaller, more complex and geographically dispersed family networks are becoming less capable of providing that care without additional support. Health care systems are still largely focused on cure and are not sufficiently orientated to provide care for all those who need it. However much is achieved in terms of prevention and treatment, the longevity revolution is accompanied by an added imperative: to develop a ***culture of care*** that is sustainable, affordable, compassionate and universal.
With the view to contribute to a fresh debate on a global ***culture of care***, two inter-connected events took place in Brazil in October: the Sao Paulo Longevity Forum (Oct. 15) and the Rio de Janeiro Longevity Forum (Oct. 16-17). The annual Sao Paulo Forum is part of an ongoing series of one day events on longevity. Content is overseen by Alexandre Kalache, President of ILC-Brazil. This year`s keynote speaker was Linda Fried of ILC-USA and Columbia University. The Rio de Janeiro Forum was organized by the team at ILC-Brazil (ILC-BR) in partnership with the World Demographic Association (WDA), with generous support from one of Brazil`s largest financial services corporations (Bradesco Seguros).

Discussions highlighted the need for inclusive, person-focused care firmly grounded in human rights; the importance of age-friendly environments; the value within the international development landscape of the cultural context of care; and the multiple dimensions of care, including care in the context of emergency situations and at end of life.

The outcome, approved unanimously, is the **Rio Declaration "Beyond Prevention and Treatment: Developing a Culture of Care in response to the Longevity Revolution"**. Launched in English and in Portuguese, the Rio Declaration is herewith attached.

INTERNATIONAL LONGEVITY CENTRE
BRAZIL

The Rio Declaration
"Beyond Prevention and Treatment:
Developing a Culture of Care in response to the Longevity Revolution"

Preamble

We, the professionals and organizations working with and for older persons convened at the International WDA Forum (Rio de Janeiro Oct. 16-17 2013), an initiative by the International Longevity Centre–Brazil (ILC-BR) and the World Demographic Association (WDA), co-organized by Bradesco Seguros and UniverSeg in association with the Centro de Estudo e Pesquisa do Envelhecimento (CEPE) and partners from academia, government, civil society organizations and the United Nations declare:
We celebrate longevity and population ageing which is arguably the greatest achievement of the 20th century. Globally, life expectancy at birth has increased by more than 30 years over the last century. These additional years must now be "translated into opportunities for the 21st century"(1) for individuals, families and societies. Every second, two people in the world celebrate their 65th birthday (2). Within a single century (1950-2050) the number of those aged 80 and above will have increased 26 fold, from 14 million to 379 million (3).

The speed and pace of population ageing not only relates to the number of individuals reaching old age. It also substantially depends on the number of children entering the population. Factors such as urbanization, migration, increasing gender equality in education and participation in paid work have all contributed to smaller family size. Total fertility rates are now below replacement level in 75 countries, and that number is expected to double to reach 139 countries by 2045-2050 (4).

The rapid demographic transition is now followed by a compression of the epidemiological transition, with non-communicable diseases (NCDs) becoming the most prevalent cause of death globally despite the reality that the threat of infectious diseases has not yet disappeared in many developing countries.

More and more people throughout the world are reaching much older age. While most enjoy active lives, increasing numbers will require care for disabilities produced by diseases that cannot be cured. Chronic conditions are lengthy and require a continuum of care services throughout the life course. The global disease burden has now changed but health systems are still largely focused on cure and are not sufficiently orientated to provide care for all those who need it. However much is achieved in terms of prevention and treatment, accompanying the ***longevity revolution*** is an added imperative: to develop a ***culture of care*** that is sustainable, affordable, compassionate and universal.
We understand that the contexts in which care provision is needed are culturally diverse and undergoing rapid change. Smaller, more complex and geographically more dispersed family networks are becoming less able to provide care without additional reinforcement. There is a growing global crisis of "family insufficiency".

Declaration

We unanimously declare the following:

1. We signal the need for a fundamental shift in the paradigm and call for the laying of the foundation of a global "culture of care" that places the person – as both the receiver and provider of care – at its very heart and promotes intergenerational dialogue and solidarity.
2. We reaffirm the United Nations Principles for Older Persons (5) and fully endorse their emphasis on independence, dignity, self-fulfillment, participation and care. These principles should be embedded in all actions on care.
3. We urge governments, intergovernmental agencies, civil society, and the private sector to respect, protect and guarantee the human rights of older persons who may have a reduced capacity to effectively exercise these rights due to frailty, cognitive impairment, disability or isolation.
4. We endorse a human rights approach to care provision because it provides the best opportunity for delivery in a non-discriminatory and equality-promoting manner where services are not only available but accessible, appropriate, affordable, of good quality; and where there are adequate structural monitoring mechanisms to ensure accountability.
5. We reiterate the 2002 Madrid International Plan of Action on Ageing (6) resolutions that highlight older people and development, commit to advance health and wellbeing into old age and foster supportive and enabling environments. We draw particular attention to paragraph 61 of the Madrid Plan:
"The growing need for care and treatment of an ageing population requires adequate policies. The absence of such policies can cause major cost increases. Policies that promote lifelong health, including health promotion and disease prevention, assistive technology, rehabilitative care when indicated, mental health services, promotion

of healthy lifestyles and supportive environments, can reduce disability associated with old age and effect budgetary savings".

6. We highlight that:
"the ultimate goal is a continuum of care for older persons ranging from health promotion and disease prevention to the provision of primary health care, acute care treatment, rehabilitation, community care for chronic health problems, physical and mental rehabilitation including older persons with disabilities and palliative care for older persons suffering painful or incurable illness or disease. Effective care for older persons needs to integrate physical, mental, social, spiritual and environmental factors".(7)
7. We urge all governments to implement their commitments in the Madrid International Plan of Action on Ageing and to establish national and regional targets and goals within the UN Post-2015 Development Framework (8) so that cultivating a culture of care across the life course becomes a priority for international development.
8. We acknowledge that the longevity revolution impacts every stage of the life course. It produces a retroactive effect which changes the definition and characteristics of each age group. Extended longevity means that "life is becoming more like a marathon than a sprint" (9) and we must all adjust and plan accordingly.
9. We emphasize the importance of the gender dimension of care and stress the need to mainstream a gender perspective in all care policies and practices. There needs to be a reappraisal of gendered social roles across the life course. Within the context of the longevity revolution, men in particular must redefine their contribution to care provision and all health and labour policies need to be accordingly reconfigured.
10. We call attention to the fact that in most countries women live longer, more often alone and with more disabilities and frailty. Most caregivers are also women; often unrecognized, unsupported and untrained. Their care needs require very special attention.
11. We underline the imperative to identify and uproot all beliefs, attitudes and behaviours, both individual and systemic, that lead to abuse and neglect in every care setting. Everyone has a responsibility to develop a consciousness about elder abuse; both in its insidious and its most graphic forms.
12. We contend that the World Health Organization (WHO) Active Ageing Policy Framework (10) provides a valuable approach to address the rights and needs of older persons. Its four pillars – health, lifelong learning, participation and protection – are a useful reference to ensure accessible, appropriate and quality care in all types of settings.
13. We acknowledge the value of the WHO-directed work on age-friendly communities and cities (11) for its contribution to a culture of care. Quality care and support in an appropriate environment is a fundamental human right of every human being (12).
14. We stress the importance of highlighting the rights and specific care needs of older persons in the planning and response to natural and conflict-related emergencies that disrupt or destroy habitats.
15. We emphasize that a culture of care must accommodate a chronic care perspective which transcends merely the provision of medication. We highlight five key elements leading to a better system of care: communication, continuity, coordination, comprehensiveness, and community linkages (13).
16. We recognize that dementia and frailty are complex care challenges of growing magnitude. We endorse the Cape Town Declaration on a Global Response on Dementia proclaimed by the International Longevity Centre Global Alliance (14).
17. In consideration of the risks and consequences of many disabling conditions in later life, we highlight the unprecedented increase in preventable blindness and deafness; critical health issues which often require early diagnosis and access to affordable treatment and rehabilitation.
18. We draw attention to those conditions that are increasingly more common as individuals reach very old age and which can have a significant impact on their quality of life. Some, such as incontinence, are stigmatized and may severely affect socialization while others, such as foot-care, may be detrimental to mobility, equally reducing the capacity to maintain social relationships.
19. We additionally note that there is a need to promote healthy skin over the entire life course to mitigate damaging environmental exposures and to reduce complications resulting from skin lesions such as bedsores and ulcers. We also recognize the particular importance of skin care and hydration in older age and the valuable contribution in falls prevention of treating painful skin conditions.
20. We emphasize that the culture of care must extend to the very end of the life course, through the promotion of palliative care which is understood as the complete relief and prevention of physical, psycho-social and spiritual suffering as long as the person is alive.

Call to Action

We commit ourselves to promote the development of a holistic culture of care – firmly rooted in respect for the individual and the highest possible values and principles – in all appropriate national and international forums. We further call upon all governments, policy makers, professionals, civil society, older persons and their organizations, the private sector and the media to invest in, to support, and to undertake the following actions:

Rights of older persons

- Create mechanisms for participation and consultation for older people about their care needs in order to develop and strengthen formal and informal care (15);
- Fully include older people at every level in decision-making regarding their care.

Care services

- Promote self-care and support older persons to self - manage their conditions;
- Provide respite care for families and other caregivers;
- Establish and support self-help groups and other community-based services to support informal caregivers;
- Provide well-designed mental care services that range from prevention and early intervention to treatment service provision and the management of mental health problems;
- Provide "low tech, high touch" end-of-life care focused on comfort and caring presence as long as the person is alive.

Planning and delivery of care

- Use evidence to support decision-making to develop comprehensive care strategies;
- Develop evidence-based treatment plans and support care providers to implement them in a range of settings;
- Facilitate research into different care models and systems;
- Implement guidelines and protocols to support the decision-making of health professionals;
- Create care delivery mechanisms that assign clear roles and responsibilities to all those involved in the care of an individual;
- Establish standards of care with mechanisms to efficiently monitor and evaluate care in all settings, including in the home;
- Develop clinical information systems that are timely, accessible and ethically sound.

Education and Training

- Strengthen appropriate geriatric and gerontological training of health professionals in all care settings, starting with Primary Health Care;
- Provide information and ongoing training on the care needs of older persons to informal caregivers;
- Improve health literacy across the life-course, including the capacity of care providers to communicate effectively with older persons;
- Increase media representation and debate to raise public consciousness of the need to develop a culture of care at all levels;
- Educate persons of all ages, including informal caregivers, to challenge the stigma of ageing and to be aware of the rights of older persons;
- Inform the public on age-related diseases, including mental health issues.

Environments for a Culture of Care

- Build genuinely age-friendly environments that foster both high-quality informal and formal care;
- Provide, and inform about, housing options that are affordable and foster independence, self-fulfillment, participation, dignity and high-quality care;
- Eliminate physical, social and economic barriers to high quality care;
- Establish adequate income security systems that enable people in need of care to make appropriate choices.

We ask all people to reflect upon the dynamic realities achieved by the longevity revolution and invite them to participate in a journey toward the evolution of a truly global culture of care.

References

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15 The term "informal caregiver " refers to caregivers who provide care in the context of a personal relationship with the care recipient, and are usually family members, friends or neighbours. In contrast, "formal caregivers" provide care in the context of an occupation that is usually paid, but that may be voluntary. Contrary to its connotation, "informal" care is not casual or economically insignificant.

The International Longevity Centre Global Alliance (ILC Global Alliance) is an international consortium of member organizations.

The mission of the ILC Global Alliance is to help societies to address longevity and population ageing in positive and productive ways, typically using a life course approach, highlighting older people's productivity and contributions to family and society as a whole. The Alliance member organizations carry out the mission through developing ideas, undertaking research and creating forums for debate and action, in which older people are key stakeholders.
The ILC Alliance centers work both autonomously and collaboratively to study how greater life expectancy and increased proportions of older people impact on nations around the world.
The priorities of the ILC Alliance are:

1. To identify productive aging as an important topic, not just paid employment, but also the continuing talent and contributions of older people; and
2. To promote educational, research and policy initiatives which will advance an active, healthy life throughout the lifecourse.

Infos

La Tuberculose Recule mais Reste un "Problème Majeur"

La tuberculose, qui a tué 1,3 million de personnes en 2012 dans le monde, a reculé pour la 3e année consécutive mais elle demeure un "problème de santé majeur", a souligné, le 23 octobre, l'Organisation mondiale de la santé (OMS). En seconde position juste après le sida, la tuberculose reste l'une des maladies infectieuses les plus meurtrières au monde.
Selon le rapport annuel de l'OMS sur la tuberculose, 8,6 millions de personnes ont contracté le bacille en 2012 (dont 1,1 million également contaminé par le virus du sida), contre 8,7 millions l'année précédente, soit une baisse de 45 % depuis 1990. Vingt-neuf pour cent des cas ont été détectés en Asie du Sud-Est, 27 % en Afrique et 19 % dans les régions du Pacifique-Ouest. A elles seules, l'Inde et la Chine ont enregistré respectivement 26 % et 12 % des cas.
Les décès sont tombés à 1,3 million (dont 320 000 étaient également contaminés par le virus du sida) dans le monde, contre 1,4 million l'année précédente. La mortalité avait atteint un sommet en 2003, avec 1,8 million décès.
Mais pour l'OMS, "la tuberculose reste un problème de santé globale majeur". Des progrès sont réalisés, "mais pas assez vite", estime-t-elle, soulignant la persistance de graves difficultés. Tout d'abord, en 2012, seulement quelque 5,7 millions de nouveaux cas ont été signalés. Ce qui signifie que près d'un tiers des cas estimés ne sont toujours pas signalés, un chiffre stable par rapport à l'an dernier.
L'OMS s'inquiète également de la progression de la tuberculose multi résistante (TB-MR) qui est une forme de tuberculose causée par un bacille qui résiste à au moins l'isoniazide et la rifampicine, les deux traitements antituberculeux standards les plus efficaces