SEA-GER-16

Strategic Directions for Strengthening Active and Healthy Ageing

Report of the Workshop on Active and Healthy Ageing for Mega Countries, New Delhi, 30 September –2 October 1999

WHO Project: ICP AHE 001

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1. INTRODUCTION

The WHO mandate which is to promote health and well-being throughout the life span, also includes the promotion of quality of life of old people.

The vast growing number of older people in the world has proven that problems of ageing and the elderly are global in nature and do not belong only to the developed world. In the South-East Asia region; Thailand, DPR Korea, Indonesia, India, Maldives and Sri Lanka have reached life expectancy at birth of 60 years and above. Three mega countries - Indonesia, Bangladesh and India – which have a population of more than 100 million each, will need to start paying more attention and put greater efforts as they will be faced with increased numbers of ageing population and older people in the coming millenium.

A major implication of increased life expectancy is the likelihood of an increase in the prevalence of physical disabilities among the elderly. While some physical capabilities deteriorate with age, it is known that many health issues associated with ageing have the potential for successful preventive action. Reflecting the rapid increase in the ageing population worldwide, health of the elderly is becoming a dominant concern as we approach the new millenium.

Many elderly, especially the young old, are not frail, vulnerable or dependent. Hence a vast proportion of them are physically healthy and financially independent. Many lead active lives. Successful and healthy ageing, which should start as early as possible, depends on the kind of choices that are made by governments and health service organizations as well as the lifestyle choices made by the individuals themselves.

The WHO Regional office for South East Asia Region (SEARO) supports countries in the formulation of appropriate national policies, strategies and programmes in the area of healthy and active ageing. In this context, there was a felt need to hold a regional workshop to develop strategic directions that can be further used by the countries as a guideline for strengthening their policies and programmes on active and healthy ageing.

A two-day Workshop on Active and Healthy Ageing for Mega Countries was held in the Regional Office, New Delhi, from 30 September to 1 October 1999. The Workshop was followed by participation in the Walk Event in New Delhi, a worldwide activity initiated by WHO to commemorate the International Year of Older Persons (1999). The list of participants and the Programme are at Annexes 1 and 2 respectively.

2. OBJECTIVES OF THE WORKSHOP

The objectives of the Workshop were:

(1) To highlight the effect of demographic and epidemiological transition in mega countries and their implications;

(2) To develop strategic directions for intercountry collaboration on strengthening active and healthy ageing;

(3) To develop a framework for advocacy strategy focusing on International Year of Older Persons and beyond, and

(4) To share information and experiences on innovative programmes on healthy ageing.

3. SITUATION ANALYSIS ON DEMOGRAPHIC AND EPIDEMIOLOGICAL TRANSITIONS AND STRATEGIES ON ACTIVE AND HEALTHY AGEING

3.1 Global

In 1998, about 355 million of the world's total population of over 60, 580 million were in developing countries. It is estimated that by 2020 seven of the ten countries with the largest elderly populations will be in the developing countries. By 2025, the population over 60 years will increase to about 1,170 million. The majority of elderly people are women, often in ill-health and vulnerable, as they are particularly poor and more likely than men to be widowed.

In April 1995, WHO launched a new programme on Ageing and Health replacing the previous programme on Health of the Elderly (1979-95). Ageing and Health programme incorporates the following perspectives:

- Life course (elderly people are not compartmentalized but are part of the life-cycle);
- Health promotion (with focus on healthy ageing/ageing well);
- Cultural (the settings that individuals 'age determine their health status in older age);
- Gender (differences in health as well as behavioural and societal attitudes);
- Inter-generational (with emphasis on strategies to maintain cohesion between generations), and
- Ethical (multiple considerations emerge as populations age: e.g. undue hastening or delaying of death; human rights abuse).

The goal of the programme is to promote health and well-being throughout the life span, thus ensuring the attainment of the highest possible level of quality of life for as long as possible, for the largest possible number of older people. In order to achieve this goal, WHO will have to further strengthen the state of knowledge about health care in old age and in gerontology. This shall be done through special training and research efforts, with special emphasis on unprecedented fast ageing of societies in developing country.

3.2 Regional

During the 1980s and 1990s, life expectancy at birth in most of the countries in the South East Asia Region has increased steadily. In 1983, only 3 out of 10 Member States had reported a life expectancy at birth of 60 years or more, whereas in 1997, 7 countries reported a life expectancy of above 60 years. As a result, the majority of SEAR countries have transformed themselves from a "young society" to "a mature society".

Similarly, 50 years ago, the life expectancy at birth in India was around 32 years. During the last five decades, it has doubled. The absolute number of elderly persons has more than tripled. By the year 2001, India will be inhabited by about 76 million elderly people constituting 7.7 per cent of the country's population. By 2020, around 11 per cent of her population will be 60 years and above, i.e. about 142 million people.

The economic, social and health status of the ever fast-growing elderly population poses a great challenge to all sectors as studies conducted in some countries of the Region reveal that the majority of the elderly population are not in a position to have an economically independent life after their retirement. In the absence of pension benefits, many old persons have to work for their livelihood until they are physically exhausted.

One the other hand, the joint family system and family values are gradually eroding. It is estimated that more than 12 per cent of the rural elderly males live alone in India. The number of lone elderly will further increase with urbanization and migration of youngsters, and decreased cohesiveness in the family bond.

Around 6 per cent of the aged in India are immobile due to various disabling conditions. Approximately 50 per cent of the elderly suffer from chronic diseases. Visual and hearing impairments are highly prevalent.

Against this background, appropriate health services for the elderly are almost lacking in majority of regional countries. Compared to a developed country, reported illness among elderly in SEAR countries is much higher. However those who visit or consult a doctor, nurse or pharmacist are much less in the Regional countries than in a developed one.

National health services in most countries are still preoccupied with the century-old scourge of communicable diseases, maternal and child health. Little attention is paid to the enormous needs of the elderly population. Geriatric services are least developed, although the elderly, one of the most vulnerable population groups, constitute more than 7% of the population.

Health personnel working at community and PHC level are ill equipped with knowledge and skills. Many of them are not aware of special needs of the elderly for health care.

Over the years, WHO has made much efforts to improve the health care of the elderly. The principal focus of WHO activities has been on community participation and family care. "Promotion of traditional family ties", particularly in SEAR, has therefore, been put ahead of "institutional care". Making optimal use of the available PHC services is the cornerstone for supporting traditional family care.

In collaboration with the Member Countries, the WHO Regional Office has been concentrating its efforts in several areas of care of the elderly. These include:

- Creation of awareness among policy makers and the general population;
- Collection and dissemination of information on socioeconomic and health status of elderly people by organizing intercountry and country studies;
- Supporting the formulation of appropriate national policies, strategies and programmes and
- Establishment of institutions or centres of excellence for health care of the elderly.

As a top priority, training of health personnel, and various studies of the determinants of healthy ageing have been receiving continued support under the WHO programmes. Several countries in the Region have recently initiated WHO-supported programmes for Ageing and Health. Yet these programmes are still young and at the development stage. They are yet to mature, while the countries are already passing from a demographically mature society to an ageing society.

3.3 Country Presentations

Bangladesh

Bangladesh had a population of 122.12 million, as per 1996 estimates. Thus it is one of the three "mega" countries in WHO/SEAR. In 1996, approximately 6.8 per cent (8.2 million) of the population of Bangladesh was aged 60 years and older. By the year 2010, 9.1 per cent (11.3 million) people will be over 60 years of age. Life expectancy at birth is 60.8 years (1998 estimates). The demographic transition in Bangladesh is due to a decline in birth rate and increase in life expectancy.

A survey on the status of the elderly was conducted by the Institute of Geriatric Medicine in Bangladesh in 1995. Its major findings were:

- 85 per cent of elderly had some form of illness.

- Noncommunicable diseases are major contributors of mortality in this age group (cardiovascular disease 15-18 per cent, diabetes 10-12 per cent and cancer 5-8 per cent of all deaths).
- Mental health problems and visual impairment are major causes of morbidity.

The Government of Bangladesh has launched several initiatives for the elderly, including pension plans, increasing the retirement age, health schemes, social awareness campaigns, legislation on reducing social inequalities and poverty, destitute homes, training programmes in geriatric medicine, etc.

India

The "aged" (60 years and older) population in India is the second largest in the world. By the year 2001, there will be about 76 million elderly people constituting 7.7 per cent of the country's population. By the year 2020, it is estimated that the population of the elderly will increase to 142 million, or about 11 per cent of the country's population.

The huge absolute numbers and large proportions of the elderly pose economic, social and health challenges. A majority of the elderly will be economically dependent after their retirement. The informal sector has minimal financial security in old age. The joint family system, which formed the main social support system for old age, is gradually eroding. With urbanization and migration of the young people in the family, the number of lone elderly is increasing.

The elderly are prone to chronic noncommunicable diseases, including cardiovascular diseases, stroke, mental disorders, diabetes mellitus, cancer, respiratory diseases, urinary incontinence, arthritis and oral/dental problems. Health services for the elderly, particularly in rural areas, are very limited.

Historically, the elderly have enjoyed a respected and secure old age within the extended joint family. Laws exist to protect the well-being of the elderly in India. The Government of India has recently launched a national policy for the elderly. Some states provide pension to all elderly regardless of their contribution to the system. But the magnitude of issues related to ageing is too large for the government to address in totality. NGOs are becoming active in programmes and projects for the elderly.

Indonesia

By the year 2000, Indonesia, with its approximately 200 million population in 1999, will have 7.4 per cent (15 million) population with a life expectancy of 65-74 years. Data have shown that 69 per cent of the older persons in Indonesia live in rural areas, 79 per cent have never been formally educated nor passed elementary school and 73 per cent live below poverty line. The 1995 National Household Survey indicated that cardiovascular diseases, neoplasma, tuberculosis and anaemia were the commonest diseases among the elderly

In 1998, a large number of older persons in Indonesia endorsed Act No. 13. on welfare for the elderly. WHO has assisted the Ministry of Health in developing and implementing primary health care for the elderly, tried out in 400 health centres throughout the country. The Ministry of Social Affairs provides homes for the elderly. Cipto Mangunkusumo Hospital , a most advanced national hospital, has provided inpatient and outpatient geriatric services for almost 10 years. However, this service mainly benefited the urban elderly.

Challenges still lie ahead. The primary health services for the elderly have not yet developed nationwide, the implementation of social security and health service insurance are in the embryonic stage and most of the public facilities are not ageing-friendly. From the demand side, many of the older persons suffer from disability, having a low level of independence, and yet, at the same time, a large proportion of the older persons who are poor still work in order to be self-supporting.

The national plan of action for the elderly, empowering older persons, training of primary health workers , research and mass campaign of active and healthy ageing are among the activities that need to be focused on in the near future.

4. TARGET BENEFICIARIES OF ACTIVE AND HEALTHY AGEING

Active and healthy ageing strategies concern everyone, from policymakers to researchers, from practitioners to every individual on earth. In a more specific

way, at the policy level, target beneficiaries are policy and decision-makers, parliamentarians, bureaucrats, local representatives and technocrats. Moving down to the implementation level, the beneficiaries will be the community, societies, families, individuals and informal and formal leaders in the community. Intermediate beneficiaries will be health providers, donor agencies, professional bodies, academicians, religious organizations, philantropic organizations, activists groups and nongovernment organizations (NGOs).

5. MAJOR AREAS OF ACTIVE AND HEALTHY AGEING

Following regional and country presentations, group discussions were held to develop recommendations on strategic directions for promoting active and healthy ageing in the Region, particularly in the mega countries. The Workshop identified the following seven major areas for discussion on active and healthy ageing:

(1) Justifications for choosing mega countries as focus of the regional meeting

A mega country, by definition, is a country with a population of 100 million and above. Although the percentage of the population aged 60 years and above in some countries is still only 7 per cent, these mega countries will face tremendous problems in terms of absolute numbers of the ageing population. The issues have to be dealt with differently for other countries with smaller populations

(2) Specific problems and advantages of mega countries in SEA Region

Mega countries in the SEA Region are India, Indonesia and Bangladesh, which are also economically developing countries. These three mega countries share common problems of the developing world, such as population density, urban-rural health problems, illiteracy, disparity of resource needs, double burden of disease, limitations in health care, low ability and knowledge of health providers, limited access and availability of health services, especially for the poor and the underprivileged groups (women, the elderly, the poor, the under five etc.).

In relation to older people, these mega countries, as other Member Countries in the Region, show a unique tradition and culture. Respect for the elderly is expressed as a shared responsibility of family members by having parents stay at their children's house and being taken care of. The existence of extended kin network in wherein parents, children, uncles and aunts are in regular frequent contact with one another is a fundamental part of the traditional welfare system. Thus, in most developing countries, the family remains the only source of support and long-term care for the elderly.

(3) Justification for emphasis for the development and programme for the elderly

Health in old age is determined by lifestyles and many risk factors that can actually be prevented during the life time. Focusing on promotion and disease prevention is a public health priority. During the life time, a person has many opportunities to maintain good health. Therefore, programmes for older persons should be based on the objective of maintaining good quality of life throughout the life span, particularly in old age. Promotive and preventive efforts should therefore be implemented, together with curative and rehabilitative efforts.

In many developing countries, which have high maternal and infant mortality rates, health of the elderly is a low priority. As ageing is a biological process, health promotion to reach active and healthy ageing during the life time are not yet geared towards benefiting the later part of life. This is not always because countries do not have a policy of protecting the elderly. Some countries have established national policies, but the system simply does not work due to many aspects, such as unpreparedness of health providers in providing proper care to the elderly and lack of awareness of the community on the importance of good quality of life in old age.

(4) Definition of healthy and active ageing as perceived by Member Countries

Although there are many documents have been published on healthy and active ageing, no clear definition on healthy and active ageing has been found so far. In order to clarify what is meant by active and healthy ageing, the Workshop came up with the following definition:

"Active and healthy ageing is a process to achieve physical, mental and social well-being of an individual, particularly in the later years ".

Since this is a life time process, involvement should start early in life. Health in the old age is the result of experiences of earlier years of life, therefore, old age should not be looked upon as a separate compartment of life, but rather as the other end of a continuum of one's life time. The pattern of living which enhances health is formed early in life and is not easily altered. The emergence of cardiovascular diseases and cancer, for example, is in fact, the result of a long-term process.

(5) The goal of healthy and active ageing

The Workshop agreed that the regional goal of healthy and active ageing should be:

"to promote health over life time in order to attain quality of life for older persons in the countries of the Region. "

This goal is in line with the integrated programme on Ageing and Health (AHE) of WHO which emphasizes the concerns on both old age and ageing.

6. STRATEGIES TO ACHIEVE GOAL OF ACTIVE AND HEALTHY AGEING

The greatest enemy of old age in the developing countries is poverty. While in the developed countries, people become rich before they become old, in the developing countries have become old before they become rich. From the perspective of health resource, strategies should ensure *equitable access and sustainable* provision of health services to elderly people.

(1) A national policy on ageing and health should be established. The national policy can be in the form of government commitment and support in the provision of social security schemes directly targeted to the elderly or other kinds of aid to support families or institutions that provide care to the elderly.

(2) A nationwide *mass awareness campaign* on special needs of the elderly should be considered as an important component of the national strategy. It is a fact that in the coming millenium, issues of ageing are unavoidable. It is also crucial that there is increased awareness among policy and decision-makers to keep abreast of these changes and the magnitude of the ageing population as well as its consequences on public health.

(3) In order to promote ageing as a public health priority, there is a need to *develop an advocacy strategy*. The strategy should be developed by government agencies, NGOs and the media, directed towards influencing public opinion and encouraging support for community-based programme for care of the elderly.

(4) Health care is delivered through an existing hierarchy of care from individual, family, health centre and hospitals. *Promotion and prevention* programmes are very important, while *early diagnosis and prompt treatment* are required to reduce disabilities and diseases of the elderly. This means that curative care is needed as a back-up support for primary health care services.

(5) The need to *train health providers* at all existing health care levels is obvious. However, priority should first be given to physicians, paramedical and other concerned health personnel at the primary health care level. The training should deal with recognizing the needs of an ageing society, ageing-related problems and knowledge and skills to respond to the needs of the elderly in the best possible way.

(6) Noncommunicable diseases are largely lifestyle-related. Active and healthy ageing strategies require increased knowledge. on how to better motivate people to *change their behaviours and lifestyles* to achieve active ageing.

7. RECOMMENDATIONS

(1) Ageing and the aged should be raised through a comprehensive approach, as a process rather than as an end product, as a problem of developed and developing countries, as a combination between community-based and hospital-based approach, and as a good balance between preventive–promotive and curative-rehabilitative aspects.

(2) To draw a common perception on active and healthy ageing among the mega countries and other Member States in the SEA Region, the following proposed definition on active and healthy ageing be accepted:

"Active and healthy ageing is a process to achieve physical, mental and social well-being of an individual, particularly in the later years".

The overall goal of active and healthy ageing will be:

"to promote health over life time course in order to attain quality of life for older persons in the mega countries of the South-East Asia Region."

(3) Most of the mega countries still lack government commitment on ageing and health. Either they have no national policy for older persons yet in place or do not have an adequate machinery to operationalize and implement the policy if it exists. WHO should support countries in the development of national policies for older persons by providing them the necessary guidelines and by facilitating the meetings of experts in the field.

(4) The gender dimension is becoming particularly important as life expectancy of women has increased and there is more recognition of higher morbidity amongst older women. Therefore, greater attention should be paid to their vulnerability. The attention should come in the form of disaggregated data on men and women as they age, more support given to elderly women who live alone and to destitutes, and granting wide recognition to gender-based differences and inequalities which affect both men and women age.

(5) The public health approach on healthy and active ageing must emphasize promotion and prevention, whereas treatment and rehabilitation are complementary. The knowledge and information on risk factors that affect healthy and active ageing in later years should be studied before conducting any interventions.

(6) To promote and strengthen ageing and health programmes in the Region, it is important that a mechanism for collaboration between individuals, academic institutions, NGOs and governmental officials is developed. A regional expert group in the field of ageing and health should also be established.

(7) Information on ageing and the elderly is very important to convince decision makers, administrators and care professionals to emphasize the importance and magnitude of the problems of ageing and the aged, and

for inputs on the planning process. The information infrastructure has to be strengthened by establishing information centres/clearing houses on trends in ageing and health in the Region, and such studies and surveys as are most relevant to health and social services, particularly for the developing countries, should be conducted through maximum use of centres of excellence and collaborating centres.

(8) Information on the health aspect of ageing, presented in a range of formats suitable to the characteristics of the target receivers, should be regularly distributed to professional care-givers, ageing individuals, policy makers and the academic community, by making full use of electronic communications.

(9) To assist countries in planning and implementing programmes in active and healthy ageing in the right direction. It is necessary to conduct specific research in the following areas: (a) epidemiological transition, (b) pattern of population ageing, (c) determinants of healthy ageing, and (d) community-based care of the elderly.

(10) The WHO Regional Office should develop standard research protocols and provide training to researchers in the area of ageing and elderly health.

(11) Considering the unique culture of joint family in the SEA Region, all advantages in promoting family-based care for elderly persons should be maximized. This can only happen if community members are empowered to be involved right from the early planning stage.

(12) The following important areas of training were identified for strengthening the implementation of ageing and health programme in the SEA Region: (a) training of primary health care workers; (b) pre-service training; and (c) epidemiology of ageing. SEARO should develop training manuals and guideline in order to assist countries to undertake effective training.

Annex 1

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Annex 2

PROGRAMME

Thursday, 30 September 1999

0830 –0850 hrs	Registration
0900 –0930 hrs	Inaugural Session
1000 –1300 hrs	Situation analysis on demographic and epidemiological transitions and strategies on active and healthy ageing
	– Global (HQ) and Regional
	Country
	– Bangladesh
	– India
	– Indonesia
	Discussion
1300 - 1400 hrs	Lunch Break
1400 –1500 hrs	Proposed strategies on active and healthy ageing,WHO/SEARO
1500 –1515 hrs	Introduction for group discussion
1545 –1630 hrs	Group discussion
	Expected outcome of group discussion
	– Strategies for strengthening active ageing
	– Framework for advocacy strategy on active and healthy ageing

Friday, 1 October 1999

0900 - 1230 hrs	Group discussion (contd.)
1400 - 1530 hrs	Presentation of group reports
1530 - 1600 hrs	Recommendations and adoption of draft report
1600 –1630 hrs	Valedictory Session and Closing Remarks

Saturday 2 October 1999

0900 –1200 hrs	Join the International Walk for All Ages in New Delhi