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HEALTH OF THE ELDERLY AND
PROBLEMS OF THE HANDICAPPED ELDERLY

CONTENTS

	<u>page</u>
1. Aging - A Challenge for Society	1
2. Are the Elderly a Homogeneous Group?	1
3. Unprecedented Demographic Trend in Global Aging	2
4. Socioeconomic Implications of the "Greying" of Nations	3
5. Major Causes of the "Greying" of Nations	4
6. Health Status of the Elderly	4
7. Some Issues to Consider in Planning for the Elderly	6
8. Situation in the EMR Member States	7
9. Promoting the Health of the Elderly: Time for Action	9
10. Primary Health Care for the Elderly in Rural Areas	10
11. Preparing for the Elderly of Tomorrow	10
12. More Situation Analysis Needed	11
13. Care of the Handicapped Elderly	11
14. Regional Strategy for the Elderly - Proposed Plan of Action	12
15. National Programme for Health Care of the Elderly - Proposed Outline	14
16. Research on Health of the Elderly in the EMR	15

HEALTH OF THE ELDERLY AND
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1. Aging: A Challenge for Society

Growing old is part of every human's life cycle, and indeed of all biological existence. A long life, preferably a happy, comfortable long life, has always been a goal in human imagination and striving. A long life used to be the privilege of comparatively few, as recently as the first decade of this century, but it is now a prospect for more and more people throughout the world. A long life expectancy at birth is now a reality for many, even in developing countries. Despite the fears and concerns expressed worldwide concerning the phenomenal increase in the number of old people, and the need to provide for their well-being, this addition in longevity is, in itself, a concrete and visible triumph of socioeconomic development. Medical technology and health care are indeed responsible in large measure for this increase.

Desirable as it is, the aging population brings with it new challenges and demands for which most countries are not fully prepared, certainly not in the developing countries. The implications of the term "health of the elderly" is not yet fully understood, and the responsibilities of government to them are yet to be realized by many administrators and decision-makers in the health and social-welfare sectors; the unpleasant prospect that quality of life may decline as life expectancy increases is the only fact that is often articulated with concern among them. For example, coronary heart disease, cerebrovascular disorders and cancer are already recognized as the main killers of those who, due to medical advances, are living to more advanced ages. More disturbing are the effects of a number of clinical disorders responsible for crippling morbidity, characterized by disability and handicap, among this segment of the population. Cardiovascular disorders, the after-effects of cerebrovascular stroke, various grades of dementia, of which the most cruel form is Alzheimer's disease, are examples of such morbidities. A simple fall by tripping on the doorstep or on the carpet, or an attack of bronchitis--a passing episode in other age groups--can be the cause of life-long disability, or even death, among the elderly, a fact which emphasizes the vulnerability of the elderly. For example, a relatively benign urinary incontinence, affecting a segment of elderly females, could completely restrict their life-style.

2. Are the Elderly a Homogeneous Group?

Since aging is a continuous process from birth, at what stage does one become elderly? The United Nations defines 60 years as the age of transition of people to the elderly segment of the population. Usually, in an official document, unless otherwise stated, the heterogeneous population of those aged 60 years and above, is described as elderly people. However, both developed and developing countries have tended to define "old" at a certain pre-established point in a human's life. Retirement from full-time gainful employment, even when financial security in the later stages of life is guaranteed by a pension or some other socioeconomic arrangements or "safety-net", has now become the "artificial cut-off point" at which an individual is known as an elder, or an old person.

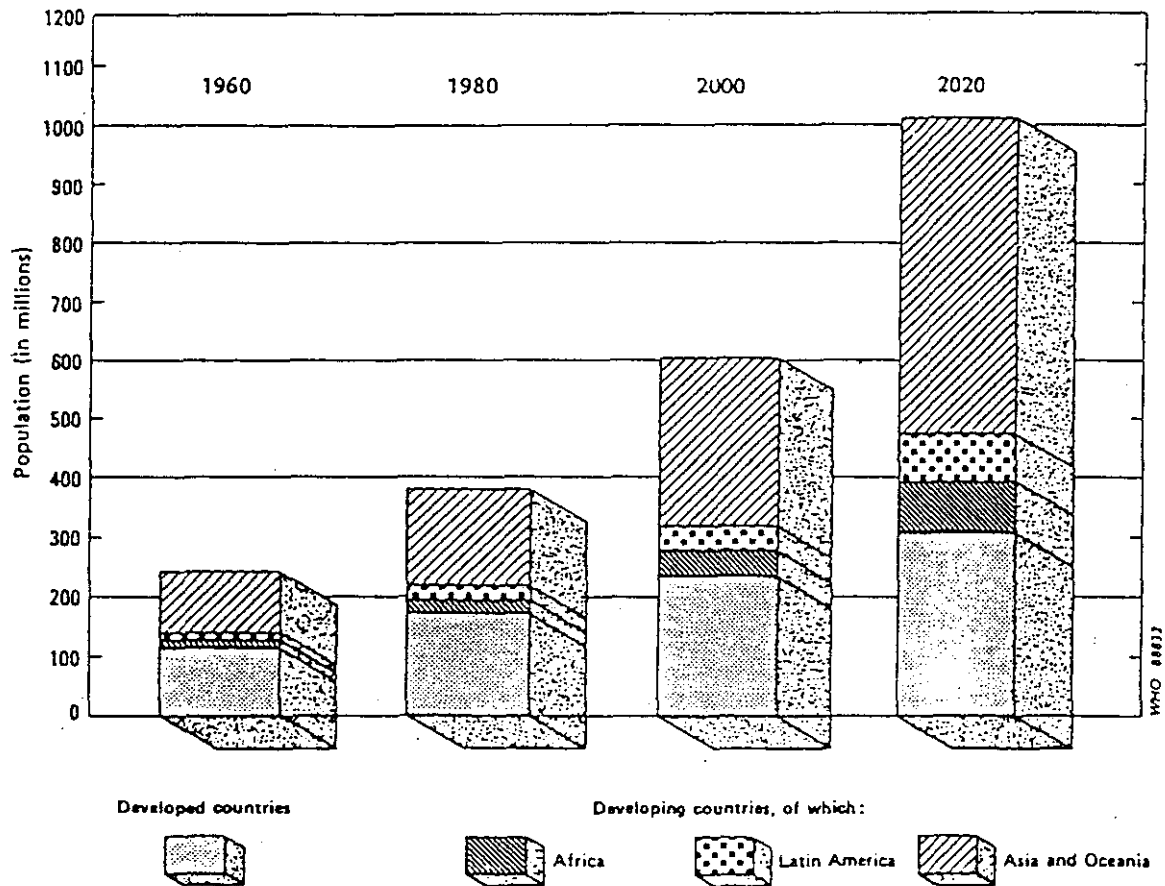
A question often asked by planners responsible for health and social care of the elderly is whether the population known conventionally as the elderly (or in some countries as "senior citizens"), is a homogenous group? The answer is emphatically no! Indeed, the variation in individual capacity increases with age from a health perspective. The policy-maker should remember that if the stage of an elderly person's life is considered as the period between retirement and death, it will cover in developed countries, certainly among the relatively affluent segment of the population, an average span of two or even three decades, a period during which the physiological, emotional and functional differences between those in their sixth decade and those in their eighth decade of life might be as marked as those between an adolescent and a person of middle age. For the policy-makers, it is essential to consider this difference, and to categorize the "elderly" into two groups: "young old" and "old old", for the planning of their total care, and not to group them together. While the "young old" can be utilized for the benefit of the community and of society in numerous ways, in addition to being of invaluable help in the home (e.g., if living in an "extended" family), thus being economically and socially productive, the other group of "old old", usually over 75 or 80 years of age, should be taken care of through different measures. They are extremely vulnerable to all types of health hazards. These are the elderly who often have anatomical and physiological impairments that can disable and handicap them. Thus, home, community or institutional-based measures are essential for this group; however, considerable financial resources are needed. A matter of serious concern for long-term planners and demographers is the relatively large increase in the number of "old old" elderly (80 years and above) compared with the growth of the total elderly population (i.e., 60 years and above) in all developed and in many developing countries.

3. Unprecedented Demographic Trend in Global Aging

Aging is an important issue in developed and developing countries. The unprecedented demographic trend, which is being witnessed today, shows a rapid increase in the older segment of the population in both absolute and relative terms. In other words, not only are there many more elderly persons today than ever before, but the proportion of older people in the general population is rising. Today, in most European countries, about 12-14% of the total population are of 60 years and above, whereas in most EMR Member States, the 60+ population is between 3% and 4%. However, in both categories, the proportion of the elderly is rapidly increasing, more so in the developing world. By the year 2000, the United Nations Population Division estimates that roughly 2 out of 3 of the world's 600 million elderly people at that time will be living in developing countries, compared with about 50% in 1960 (see Figure 1). Although this phenomenon has been, for decades, occurring predominantly in the industrially developed countries of the West, most developing countries have already started showing signs of this demographic trend. The increase in the elderly population in developing countries will be particularly marked in Asia, primarily as a result of the rapid growth expected in the number of aged in China and India. These two countries alone will add 270 million elderly people by the year 2020. Pakistan, an EMR Member State, will add 10 million elderly persons during that period. Developing countries will gradually replace European countries in rank as having the largest elderly population.

What is more disturbing is the fact that in a large number of developing countries, the population aged 60 years and over is increasing at a faster rate than the population as a whole. Thus, between 1980 and 2020, the total population of developing countries is expected to increase by 95%, whereas the elderly population will probably rise by almost 240%! Not only is the aged population increasing in the developing world, but the elderly population is itself getting older, as more and more people survive longer.

Figure 1. Population aged 60 years and over, by major world regions, 1960-2020*



Source: United Nations Population Division.

* Reproduced from: WHO. *World health statistics annual, 1987*. Geneva, World Health Organization, 1987.

4. Socioeconomic Implications of the "Greying" of Nations

This "greying" of the population, worldwide, has tremendous socio-economic and health implications which, as mentioned earlier, have not been adequately comprehended by planners and decision-makers in developing countries. A matter of further concern is the fact that women will constitute a much larger proportion than men in most countries of this "aged segment". Global epidemiological data indicate that the morbidity pattern of the elderly female is of much more serious concern than that of the elderly male. Some visible trend due to this demographic change are:

- An increase in the proportion of the population aged 60 years and over. A decreasing number of economic "producers" will have to look after an increasing number of "consumers";

- An increase in the population of the very old among the elderly population; this segment has the highest demand on medical and social services;
- A predominance of women among the elderly population. With a high morbidity pattern of elderly women, the demand on the medical, social and health services and infrastructures will go up steeply;
- A predominance of the rural character of the elderly population in developing countries, which implies the necessity of developing rural facilities for the elderly. Elderly parents will quite often be left behind in villages, while the adult segment migrates to urban areas;
- A shift towards the aging of the overall population with a decreasing number of children. This has been observed as a major reason for the sense of "loneliness", which leads to depression and dementia in the elderly, mostly in the developed countries.

5. Major Causes of the "Greying" of Nations

Making people live to "ripe old ages" is certainly evidence of medical triumph. Better medical and health care, associated with other socioeconomic developments, have brought down mortality rates not only of infants and children, but also of the older population, with the help of modern technology. Life expectancy at birth in most developing countries is rising. Life expectancy, even at 40 and 60 years of age, is showing a distinctly upward trend. An infant born today in any of these countries has a better chance, more than ever before, of reaching old age. This is the major reason for this demographic trend.

The second major reason for this demographic trend are the falling birth rates in a large number of countries. As observed by a sociologist in the West, "One finds more wheelchairs than perambulators in the parks". The proportion of elderly rises steeply according to the fall in infant population.

These two major factors complement each other in most developed countries in producing the relative and absolute increase in the 60+ population. On the other hand, in most countries in the Gulf region, the birth rate has not declined, but the crude death rate has shown a steep decline, along with a significant increase in life expectancy. In such cases, the proportion of the population in the age group of 60+ will be much lower than that if both the causes would have worked together, but the absolute number of people in 60+ group will, however, increase rapidly.

6. Health Status of the Elderly

Information about the health status of the elderly in most countries, especially in developing countries, is conspicuous by its absence. Where such data exist, they are limited to mortality data, which are less reliable for the elderly owing to multiple pathological conditions often present at the time of death. Mortality data do not always accurately reflect the underlying morbidity, and are particularly inappropriate for many conditions for which the fatality rate is low, yet which are important causes of morbidity among the elderly. With few exceptions, comprehensive morbidity data are not available for the elderly, and hence, health status can only be assessed through analysis of mortality.

Roughly 50% of all deaths in developed countries, as well as among the moderately affluent population in developing countries, is attributable to cardiovascular diseases. Cancer accounts for 25% of deaths among men and women in this age group, and roughly 7% of deaths are due to respiratory conditions. Pneumonia and diabetes are also common causes of death among the elderly in many countries, under certain situations. Death rates due to accidents are more than three times that for old people as for people of all ages. After the age of 65 years, deaths from all accidents rise sharply with increasing age; about six out of every ten fatal accidents of the elderly result from falls, most frequently in the home.

The aged population has special health problems that are basically different from those of the adult or younger population. Unfortunately, this is not yet adequately appreciated by health administrators in most developing countries. Even in developed countries, this realization came rather late with the result that this demographic phenomenon found them rather unprepared. The task of taking care of the health of the elderly will continue to increase, since every major advance in medical science and the accumulated benefits of socioeconomic development will increase their number. The health care system in all developing countries should incorporate "gerontological principles" in all health care measures for the elderly. Health problems of the elderly have special features, some of which are:

- The most common diseases of the elderly are chronic in nature, e.g., cardiovascular diseases, arthritis, orthopaedic impediments, mental disorders, loss of hearing and vision, and infectious diseases.
- While disease processes in the elderly are more insidious in onset and development than in the adult population, the outcome is serious. Bronchitis is often fatal in old people, but a passing episode in the younger population.
- Disease processes in the elderly are often multiple in nature, with the result that the final clinical picture is extremely confusing.
- Undiagnosed and unreported diseases and disabilities are extremely common in the aged, and, as a result, they come usually at an advanced stage of the disease. There are many reasons for this, the most important being the absence of a "caretaker" for most "very elderly" persons. Secondly, there is a general belief among the elderly that old age is a time of ill-health, disability and mental depression, and that many health problems should be regarded as a "way of life of the aged", and are, hence, not reported for medical attention.
- There is a high incidence of complications of disease and treatment. Dose-related complications of drugs are more common in the elderly.
- Prolonged rehabilitation is almost a rule in health disorders of the elderly.

Several careful studies in the Western world have demonstrated that both underdiagnosis and overdiagnosis are common in the elderly. The elderly themselves are often convinced that many of their problems,

both somatic and mental, are due to age and therefore they do not mention these complaints to their doctors and, as such, underdiagnosis is a common feature in most cases. Urinary incontinence and depression are typical examples of problems which are not mentioned by the elderly to their physicians. Another reason for underdiagnosis is that symptoms are often confused in the elderly.

These studies also demonstrate that overdiagnosis is also extremely common, with physicians interpreting the manifestations of aging as a symptom of disease. The supposed prevalence of hypertension and diabetes in the elderly illustrates this problem. There are areas where adequate diagnostic criteria in the elderly are lacking at the present moment. An important area for study is to collect data related to the clinical chemistry of the aged in order to establish a normal range of values in this group to facilitate correct diagnosis.

7. Some Issues to Consider in Planning for the Elderly

The demographic trend mentioned earlier has far reaching diverse implications for the planning of programmes for the care of the elderly, and the major implications include the following:

1. It is often stated that in a "greying society", the ratio between the economically productive and the nonproductive population will steadily decrease, so that a smaller number of economically productive people will have to provide for an increasing number of aged people whose productivity has either decreased or completely ceased. This can be regarded as an economic burden, especially in developing countries of the EMR where birth rates are still high and therefore the young adult population will have a very large dependent population - both children and aged relatives, sometimes belonging to two different generations.

However, this economic argument is not always valid and developing countries should take note of this fact. Many elderly men and women provide invaluable help in individual homes, and this goes unrecorded in most cases. The economic productivity of many women with children, who are employed outside their home, depends on the presence and help of aged parents at home. Aged populations are also sometimes of great benefit to the welfare of the community and society, but this is very often not recorded as economically productive work.

2. The pattern of health care and social welfare services will have to be reoriented in order to design them for the needs of the aged population. In developed countries, geriatric centres are replacing creches and day-care centres for infants and children. In developing countries, welfare centres for infants and children will have to continue for decades. A feasible approach will be to utilize the elderly population in infant and child-care centres which, in turn, will promote the physical and mental health of the elderly.
3. For most developing countries, institutional care of the aged is not ideally suited for cultural and economic reasons. First, institutional care is expensive, and thus not feasible for most developing countries. Second, transferring aged parents to an old-age home for institutional care is often regarded as "cruel", resembling "geriatric apartheid" in the cultures of most developing countries. Clearly, a different approach is needed for the care of the elderly, concentrating on home and community care.

4. The disease and disability pattern of the aging population is distinctly different basically due to impairment of their physiological and mental functions. Excepting mortality and morbidity due to accidents, to which the aged population is extremely vulnerable, other diseases and disabilities are of a chronic nature, for which appropriate infrastructure and personnel are necessary. Home-based care should be the answer for any programme for the care of the elderly, and for which creating awareness between the "care-giver" and the recipient is an essential requirement.
5. In the planning for the care of the elderly in countries of this Region, it will be prudent to examine first the existing cultural practices for the care of the aged family members. By and large, the quality of care of elderly relatives in the home is usually regarded as a source of pride. Most cultures regard their elders as sources of wisdom and sanity. Sending elderly parents to "old-age homes" is even now, in most cases, considered by society as not fulfilling one's familial responsibilities, and thus, a matter of shame.

A note of caution should be sounded here. With rapid urbanization in developing countries, associated with massive migration to urban areas, the tendency of the young, economically productive migrant is to create a "nuclear family" (as opposed to an "extended" family) in the not-so-hospitable urban and periurban settings, leaving elderly relatives in their rural homes.

The real focus in any strategy for care of the elderly should logically be directed towards this vast elderly population in rural areas of most developing countries, who are deprived of "care-givers" within the family, and for which the "cultural norm", mentioned above, does not exist.

8. Situation in the EMR Member States

EMR Member States have not yet experienced a situation where their elderly population is viewed with concern. No single EMR Member State has voiced this concern publicly. Of course, public sympathy for the uncared for aged people has led to the formation of many voluntary agencies in many countries. However, these are mostly in the private sector in the form of nongovernmental organizations (NGOs). Except for Cyprus, where the percentage of the total population over the age of 65 years is 10.4%, almost comparable with most European countries, at 12%, most other countries of the Region do not have an elderly population at more than 2-4% of their total population. A recent compilation of country data relating to crude birth and death rates, life expectancy at birth and percentage of total population in the age group of 5 years and below and 65 years and above, is presented in Table 1, which shows the interdependence of these vital indicators.

While this demographic trend in developed countries has been brought about by a drastic reduction in fertility and an increase in life expectancy, EMR Member States have still not been able, in most cases, to bring down their fertility rates. In many affluent, but underpopulated countries, especially in the Gulf region, the national policy is to promote population growth. In these countries, the proportion of elderly population will not show any significant increase, but the absolute size of this population will steadily increase. In most developed countries, the ratio of the elderly to the working adult population is increasing,

Table 1. Some vital statistics and demographic data of EMR Member States, 1988-1989

Member States	Crude birth rate	Crude death rate	Life expectancy at birth (years)	Percentage of pop. under 5	Percentage of pop. over 65
Afghanistan	47.5	28.0	42	20	3.7
Bahrain	30.2	3.8	71	13	2.2
Cyprus	18.7	8.9	76	10	10.4
Djibouti	47.3	17.7	47	17	2.2
Egypt	40.7	9.1	61	14	2.9
Iran, Islamic Republic of	37.7	6.3	67	16	3.5
Iraq	44.4	8.7	66	17	2.7
Jordan	44.0	10.0	69	18	2.6
Kuwait	30.0	2.4	73	14	1.2
Lebanon	28.9	7.8	67	17	5.1
Libyan Arab Jamahiriya	43.9	9.4	61	21	2.3
Morocco	34.8	9.1	62	16	4.0
Oman	46.0	15.0	57	19	2.5
Pakistan	40.0	10.0	61	15	4.2
Qatar	29.7	2.3	73	11	1.1
Saudi Arabia	43.3	8.0	63	20	2.9
Somalia	50.8	20.3	45	18	2.7
Sudan	44.6	15.8	50	17	2.8
Syrian Arab Republic	41.8	8.2	65	19	4.4
Tunisia	31.1	6.7	66	15	3.8
United Arab Emirates	35.0	2.0	71	16	1.5
Yemen, Republic of	53.0	19.8	51	20	3.4

though the ratio of the child population to the elderly population appears to be declining. In developing countries of the EMR, the "youth" segment is very much larger than the "old" segment and is likely to remain so for years to come. However, high birth rates and reduced death rates are enlarging the population of developing nations very rapidly, setting the stage for rapidly expanding the elderly population in the future.

The following are some important features of the demographic pattern relating to the elderly in EMR Member States.

1. The countries in the Region expected to have higher numbers of 65+ population are the Gulf states, due primarily to their rapidly rising life expectancy. In reality, the proportion of the population of 65 years and above for Bahrain is 2.2% and that for the United Arab Emirates is only 1.5%. A high birth rate and a large percentage of expatriate young population in these countries, in all probability, mask the actual percentage of the 65+ population. The absolute number will, however, reflect the increase.
2. Cyprus is the only country in the Region that has demographic patterns similar to Western Europe, with more than 10% of population in the age group of 65 years and above.

3. A number of countries, each with a fairly large population and a high birth rate, have about 4% or more of their total population in the 65+ age group. Increased life expectancy and a steep reduction in the death rate are the major causes. However, large infant and child populations mask the percentage of the elderly population. Since there are definite indications of declining birth rates in many of these countries, the proportion of the elderly population will gradually go up in the near future.
4. The situation as it stands now is indeed "writing on the wall", as far as absolute numbers of the elderly are concerned. The total number of elderly in the Eastern Mediterranean Region today is about 12 million, the same as the total population of Saudi Arabia, and this number will increase every year. The number of elderly in any given country in the Region will be so enormous in a few decades that any well-planned programme for their care at national, community and home levels will put human and financial resources much beyond the capacity of most developing countries. It is, therefore, imperative that a start be made immediately in this area.

9. Promoting the Health of the Elderly: Time for Action

While the statistical data relating to the countries of this Region might lead to a sense of complacency, the forecast of future events, in just a few decades, is certainly a matter for concern. The disturbing feature is an absence of any current data on the elderly: their precise numbers, their health status, their debilitating problems and the way they are accepted by their families, communities and societies. Needless to say, no meaningful planning can be done without such information. A start has to be made now to conduct situation analysis, and to create more public awareness.

The responsibility for developing plans for the care of the elderly rests logically on the health and social welfare sectors of the countries. The health sector obviously has to be the catalyst. It is the health sector that has the prime responsibility of planning for the health care of the elderly, which, incidentally, overlaps with the responsibility of the total care of the elderly, in which social services will have an important role to play. Also, the role of NGOs should not be underestimated.

Most developing countries have financial and technical constraints in undertaking organized programmes for the elderly. Institutional care, which is the norm in developed countries, and is expensive, needing trained human resources, is obviously not going to be the solution in developing countries. Feasible alternatives should, therefore, be considered, properly planned and put into operation.

Taking into consideration developing countries' financial and technical constraints, they have one positive factor, which is the cultural outlook in which the elderly are usually accepted in the home and in the community. In many countries of Asia, the elderly are regarded as a source of wisdom and they play an important role, not only in the home, but also in the community. However, one should not overlook the disturbing event of recent rapid industrialization and urbanization in developing countries. An increasing number of "extended families" are breaking down and are being replaced by "nuclear families" in urban areas, mostly in the

peripheral zones of shanty towns and slums, resulting in a steadily rising number of aged "uncared" for people in rural areas.

10. Primary Health Care for the Elderly in Rural Areas

By and large, the problem would be concentrated mostly among the vast rural population in developing countries, where the elderly continue to be an integral part of the family. Their health care will necessarily be the responsibility of the same health care system that provides both preventive and curative services to rural families - and this is, in most cases, primary health care. Indeed, primary health care in most developing countries is the logical answer for the health care of millions of elderly persons in rural areas. Primary health care, by virtue of some of its characteristics (community involvement and intersectoral collaboration), is in an ideal position to provide comprehensive care to the rural elderly.

However, there are certain essential prerequisites, of which the following are important:

- Adequate in-service training of community health workers for providing simple health care to the elderly, and in recognizing the early manifestations of morbidity, which might later lead to disability.
- Training of doctors and other health staff at the intermediate level to provide technical support.
- Sensitization of other peripheral workers of those sectors which might have a complementary role in providing continuous care for the elderly.

Training manuals for community health workers and their training should be appropriately modified to incorporate information on the care of the elderly.

11. Preparing for the Elderly of Tomorrow

In planning programmes for the elderly, it is important to remember the importance of the middle-aged segment of today.

Today's middle-aged people are the elderly of tomorrow. The elderly of tomorrow will differ somewhat from the elderly of today in their social and political outlook, and even in their health and physiological status. In any long-term planning, it is important to prepare the present middle-aged for their old age. Promotion of appropriate physical exercise, training for rehabilitation in cases of minor impairments, awareness about the dietary needs with advancing age and simple rules of health, are the basic needs for the middle-aged.

It has been clearly demonstrated in a number of studies in different parts of the world that properly prepared, middle-aged people can remain "young old" once they become "elderly" for a much longer period and can continue to be productive citizens. Evidence shows that they do not succumb as easily to common hazards of old age (e.g., accidents) and are better able to take care of themselves in case of impairments.

12. More Situation Analysis Needed

Fact-finding research is urgently needed to provide a base for a strategy for protecting and promoting the health of the elderly. Information regarding the present status of the health of the elderly, their main limitations in maintaining proper health, the impact of measures taken by the government or the community for the protection of their health, and many other related areas are almost unknown in most countries of this Region. The data generated would be an essential base on which planning for the protection and promotion of the health of the elderly could be developed. In the Eastern Mediterranean Region, such a type of survey is almost unknown, except in an isolated cross-country study, sponsored by EMRO, on Bahrain, Egypt, Jordan and Tunisia, the results of which are being finalized. A matter of urgency is to sponsor and initiate simple country studies based on a standardized protocol, so that the results of such situation analysis can be comparable among countries.

Cross-national longitudinal studies should also be carried out to study the risk factors for chronic diseases that afflict the elderly, and their implications as far as care is concerned. This is extremely important to understand how, in different countries and in different cultural settings, risk factors vary widely in producing chronic disorders. Physical activity, social loneliness, dietary intake and economic background might cause different impacts on the elderly, according to their culture, and this understanding is essential in formulating appropriate measures.

Health services research (HSR) is another important area to ascertain the impact of different types of health care systems on the elderly. In most developing countries, the concentration of elderly will be among the vast rural population, and it is important to know whether the rural health care system will be able to cope up with the requirements of the health of its elderly. In the coming decade, the primary health care (PHC) approach will be the backbone of the health care delivery system among the vast rural population, and, as such, measures for the promotion and protection of the health of the elderly should be formulated within the PHC system. An essential prerequisite will be to see how far the existing PHC systems in the countries are meeting those needs, and the type of modifications that will have to be made to achieve a maximum impact.

13. Care of the Handicapped Elderly

Very special consideration has to be given for the health care of the handicapped elderly. They are not only the victims of some types of impairment--physical, physiological and mental--which makes them disabled and handicapped, but, at the same time, they have all the characteristics of senility, a rather harsh term to indicate the ravages of aging. Obviously, the rehabilitative care necessary for the handicapped elderly will mean much more than what is necessary for a handicapped adult or child.

Most elderly people, especially those who are in the category of "old old", develop some degree of physical, emotional or mental illness, which impairs their normal functional ability, leading them to a stage of handicap. While some of these conditions lead to death, others might be

conditions restricting their normal life-style. Thus, arthritis, cataract, urinary and faecal incontinence are common examples of the second category.

A large number of health disorders can cause a handicap in the elderly, but the following are the important ones:

- cardiovascular disorders;
- after-effects of cardiovascular accidents (e.g., stroke);
- cancer;
- orthopaedic disabilities, including osteoporosis and hip fractures;
- arthritis of various types and grades;
- depression and senile dementia;
- diminished hearing or vision;
- urinary and faecal incontinence.

In developing a plan of action for the handicapped elderly, it is obvious that home-based care is the solution for most cases. Fortunately, this is, even now, the norm in most developing countries. As an extension of individual families, communities provide the necessary backstopping. What is most important is to support the "informal caretakers" in individual homes and in communities through adequate simple training. Cataract, a common cause of handicap among the elderly, could be tackled by community-based "eye camps", which have proved feasible and inexpensive in many developing countries. The health care system, with some orientation in geriatric principles, and with the active support of the community, could organize such camps in most rural communities. A properly oriented health care system, with primary health care as a central approach, in collaboration with the community, would be able to provide the necessary care in most cases of the handicapped elderly. There would, however, be a small percentage of the handicapped elderly who would need specialized institutional care.

14. Regional Strategy for the Elderly - Proposed Plan of Action

Concerted action, in collaboration with Member States, will have to be taken immediately to assist countries to face this problem in the very near future. The collection of baseline information about the extent and magnitude of this problem is of immediate necessity. It is proposed that instead of *ad hoc* measures by Member States, it would be more appropriate to develop a comprehensive regional strategy, within the framework of which necessary support and assistance would be provided to Member States. The following steps are suggested for developing such a strategy:

14.1 Focal point for health of the elderly

Member States must face the problem themselves. It is of utmost importance to provide the technical support and background data needed by Member States to enable them to cope with this responsibility. The first step would be to request each country to establish a "focal point" for the elderly in the health sector, to whom the Regional Office would provide background data and technical support.

14.2 Compilation of a national profile on the elderly

The next step would be to collect and compile all available information, through the focal point, on the following:

- the approximate size of the aged population in the country, based on census data, the socioeconomic distribution and the disability pattern of the elderly;

- existing government set-up for assessing the problems of the elderly, and undertaking measures to ameliorate these problems;
- any awareness campaign being conducted by the country to make the general public aware of the problems of the elderly; and
- the role of NGOs in dealing with the problems.

14.3 Compilation of a regional inventory of health problems of the elderly

Once this has been achieved through the national focal points, and for which the Regional Office would provide all technical back-up, a regional inventory would have to be compiled by the Regional Office, based on country profiles on the size of the elderly, their major health problems and actions being taken, either by government or the private sector. This compilation would serve as resource material, indicating specific problems of the elderly, their priorities, measures to be taken by government and voluntary agencies and areas needing attention in the immediate future.

14.4 Intercountry consultation on health care of the elderly

An intercountry consultation should be convened in June 1992, in which the major background paper would be the above-mentioned resource material. This intercountry consultation would serve to expose country representatives to the problems of the elderly in the Region; it would enable an exchange of experiences as to how the problems are being dealt with in individual countries, their strengths and weaknesses; develop strategies, strengthening them wherever these exist; and identify areas where external support would be necessary.

14.5 Regional working group on health of the elderly

The establishment of a Regional Working Group on Health of the Elderly would therefore be the next logical step to serve as an over-viewing body. It is proposed that the group might be composed of three or four national experts, who would be identified in the intercountry consultation, one or two outside experts and the Regional Adviser concerned in EMRO.

14.6 Regional strategy for health care of the elderly

The development of a "regional strategy" would be the Regional Working Group's first responsibility. It is proposed that the Regional Group be established by July 1992, and by September 1992, it should develop a regional strategy. The strategy should encompass all facets and feasible measures to improve and overcome the problems of the elderly, especially relating to their disabilities and handicaps, if any. The regional strategy should have two components:

- i) country activities in which each Member State would be assisted technically in undertaking specific facets of the national programme through consultancy services; and
- ii) intercountry activities, the outcome of which would benefit all or most of the countries in the Region.

It is expected that by the end of 1992, the regional strategy would be finalized for implementation.

15. National Programme for Health Care of the Elderly - Proposed Outline

15.1 Establishment of a focal point in the health sector

The focal point in each Member State would be responsible for all issues relating to the health care of the elderly and for coordination with other sectors and NGOs. The focal point would also be in contact with the Regional Office to obtain technical support and necessary information for undertaking a basic survey for situation analysis.

15.2 Situation analysis

This is a priority area. The catalyst would be the health sector's focal point in each Member State. While situation analysis would have to be conducted in collaboration with other concerned sectors, it would be conducted in a manner that would provide information on the number of the elderly in the country, their categorization according to chronological age, the major causes of morbidity and mortality, the major causes of disabilities and handicaps, public awareness campaigns in the country, if any are in operation, any collaborative measures for the well-being and health care of the elderly by government and the private sector, and an indication of what more could be done and what type of support is needed.

15.3 National seminar

A national seminar should be convened as early as possible after the results of the situation analysis are obtained. The seminar would have representatives from the concerned sectors and NGOs, and these should be made aware of the results of the situation analysis. A collective effort would have to be undertaken to prioritize the problems to be tackled immediately, assess what is being done presently, and by whom. The seminar should also indicate what more feasibly could be done in the country with the available technical and financial resources, and, if necessary, with some external support.

15.4 National campaign for public awareness

Once the seminar has been conducted, the next step should be to initiate a national campaign for creating awareness among the people regarding the problems of the elderly and the steps that could be taken at home and in the community for overcoming the problems. Such an awareness campaign should also be designed for "informal caretakers" in the home and the community as to how to tackle the common problems of aging and prevent further impairment.

15.5 Training courses

An important task is to develop and organize, on a continuing basis, training courses for all health care staff and staff from other sectors and voluntary agencies. The training courses should be developed to provide basic information about the problems of the elderly, how to recognize these at an early stage, and simple measures for overcoming the disabilities. In this connection, it is necessary to prepare printed material for "informal caretakers" in the home and in the community in national languages and this material should be widely disseminated.

15.6 Incorporation of information about the elderly in school curricula

There are misconceptions about the elderly. The elderly are usually regarded as "helpless" individuals, needing support and pity, which certainly is not true in most cases. Important facts about this segment should be incorporated in school and university curricula, and appropriate steps should be taken by the education sector.

15.7 Intersectoral coordinating committee

The most important point to recognize about a national programme for the promotion of the health of the elderly is that the problem can only be tackled if several sectors of the government act in a coordinated manner in collaboration with the public. The need for an intersectoral coordinating body at the national level is of utmost importance. This committee should strive to obtain political commitment at the highest decision-making level.

16. Research on Health of the Elderly in the EMR

No single research project can embrace the numerous approaches possible to cover the major areas of investigation involving the health of the elderly. A number of research areas needing urgent probing were considered and approved by the Eastern Mediterranean Advisory Committee on Health Research (EM/ACHR), in Abu Dhabi in 1990. These are mentioned in the following paragraphs.

16.1 Demographic and statistical studies

As mentioned earlier, demographic and statistical data on the elderly in EMR Member States are extremely scarce. The first attempt should be to obtain and analyse country specific data from national census, death and morbidity registers, health service records, national surveys, and consumer research, and other available data relating to the health of the elderly. The report of the WHO meeting on Compilation of National Demographic and Health Profiles of the Elderly, held in Geneva, 8-9 January 1985, provides detailed guidelines.

16.2 National surveys of health and social aspects of aging

Such surveys are essential for generating baseline data relating to health status of the elderly and major socio-cultural determinants. Without such information, problems cannot be defined, nor promotional measures formulated.

As mentioned earlier, a start has already been made by EMRO in initiating a cross-national study on aging in four countries of the Region. Such a coordinated approach, with standardized survey instruments and central analysis of data, can be extremely useful for obtaining national comparable data and an effective regional database. Efforts will have to be made to enlarge this type of study to cover more countries in the EMR. Wherever possible, such studies should be extended to include some objective measures and at least a simple, performance-based function test.

16.3 Longitudinal studies

Such studies are definitely more difficult and time-consuming to conduct, but they could yield invaluable data regarding the determinants of healthy aging versus disability in a representative population within a country. A study on this scale would also be a valuable resource for training purposes, in addition to generating data for better understanding of the effects of major determinants on the process of aging in different age groups in the same socio-cultural setting.

16.4 Operational research

The aged population is rapidly increasing in most countries of this Region, though in none of the countries has this assumed such a proportion

to be articulated by demographers, health administrators or policy-makers. It is, however, prudent to recognize this problem at an early stage in order to be ready with health and social measures when the impact of this demographic trend is felt in a more palpable manner.

Operational research could be conducted on a pilot basis, initially focusing, specifically, on some already identified determinants and ascertaining the impact of ameliorative measures over a specified time period. While some of the specific areas on which attention could be focused may be identifiable at the present moment, others will become apparent as a result of the analysis of data from the studies conducted on a cross-country basis. Aging involves complex biological, psychological and social interaction processes. It is important to develop and conduct community studies that will increase understanding of how the health and well-being of older people are affected by different cultural, personal and environmental factors in the same country or in a region.

To cite an example, a major determinant of premature aging is the realization of social and family "rejection" and hence, a sense of loneliness. Simple pilot projects could be undertaken in various countries, at the community level, in which the elderly population could be utilized for taking care of the child day-care centres. This approach would not only facilitate child care at the community level, but, at the same time, would give the elderly more active responsibility and prevent the sense of loneliness and boredom. The impact of such centres on the physical and mental function of the elderly, through demonstration projects, could yield valuable results on which larger national programmes could be formulated.

A common occurrence in some developed countries as a result of this demographic trend is the rapid disappearance of day-care centres for children, and their replacement by day-care centres for old people. In developing countries, both types of centres would obviously be needed, and, as such, community studies to complement each other would be a logical solution.

16.5 Laboratory and clinical research

More basic studies on the biological and clinical changes of aging could unravel many of the unanswered questions on the aging process. Those countries in the EMR that have such laboratory and clinical research facilities might undertake studies on some of the questions that are basic for understanding aging in a given socio-cultural and geographical setting. Biochemical and physiological profiles, including functional and performance tests, are basic requirements in understanding the biological process of aging. Similarly, drug tolerance and immunocompetence in aged people are other areas. Nutrition and aging is a vast area that requires research with many unanswered questions (e.g., energy and fat requirements of the elderly, desirable dietary patterns in old age, metabolic changes, etc.).

Thirty-eighth Session

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Agenda Item 10(a)

HEALTH OF THE ELDERLY AND PROBLEMS OF THE HANDICAPPED ELDERLY

Summary of Recommendations

It is recommended

1. that Member States:

- (1) Establish and strengthen an appropriate national set-up for coordinating all activities relating to protection of the elderly;
- (2) Conduct situation analysis for rapidly assessing the size and socioeconomic character of the elderly population in each country, their health status, and existing measures in both the public and private sectors for their protection;
- (3) Formulate national strategies for the protection of the elderly, with special reference to the prevention of disability and handicap;
- (4) Encourage research in areas of operational importance;

2. that WHO:

- (1) Assist the national set-up of Member States responsible for the health of the elderly in conducting situation analysis, followed by formulation of national programmes for health protection of the elderly;
- (2) Enable national managers of such programmes to exchange experiences through inter-country workshops, thereby strengthening national capability in the implementation of programmes and in conducting operational research;
- (3) Formulate a regional strategy for health care of the elderly, in collaboration with Member States, and establish a Regional Working Group to overview its implementation.