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Ageing is a natural and inevitable process. For the past century and more mankind has been adding years to life. More people now survive the challenges of childbirth and childhood and live longer through adulthood to reach old age. This trend is not restricted to the resource-rich countries but has become a global phenomenon including the countries of South-East Asia. It has been estimated that over 8% of the population living in Member States of the World Health Organization’s South-East Asia Region are above the age of 60 years. This proportion is expected to increase to 12% by 2025, and to over 20% by 2050.

The journey into the uncharted realms of old age is an adventure of continual learning, adjustments and most important of all, mentoring what is good and admirable. This journey begins even before a person is born, right from the mother’s womb. The nourishment and care that the mother and her unborn baby receive will determine how the newborn will fare in the world. An encouraging physical, social and mental environment that ensures the well-being and growth of the infant will lead to healthy adolescence, adulthood and eventually, old age. As such, a continuum of care and support including health, that follows a life-course will ensure that ageing remains a healthy and fruitful experience and a journey of self-transformation, education and contribution.

An ageing population gives rise to several critical queries: impact of an ageing population on the national economy and its social support and health care systems; ways of ensuring the independence, quality of life and activity of the elderly population; and retaining balance between the family, community and the state in caring for an elderly population needing assistance.

Many issues of an ageing population can be overcome, delayed or prevented if the countries adopt policies and implement programmes that promote active and healthy ageing. Promoting and living a healthy lifestyle across the life-course means that the elderly population will continue to participate in social, economic, cultural, spiritual and civic affairs in addition to being physically active and economically independent.

Creating age-friendly environments and policies to engage the elderly population and utilizing their vast potential will result in dignified ageing, allowing the elderly population to participate actively in family, community and political life, irrespective of their functional ability.

The World Health Organization has embarked on promoting healthy ageing in its Member States with a multipronged approach in South-East Asia. Sensitizing and generating awareness among Member States about healthy ageing requires a significant paradigm shift in the way care is provided to the elderly population; a strategic framework to assist Member States to develop plans and strategies for promoting active and healthy ageing among the Region’s populations; and timely and appropriate
assistance to build and develop technical capacities in elderly health care. A holistic approach towards establishing healthy ageing in WHO Member States in South-East Asia will require interactions with several other sectors beyond health and WHO is mindful of this need. The large number of projects and activities witnessed in Member States in recent years has given us confidence that healthy ageing can become a part of life and society in the Member States over a short period of time.

An age-friendly primary health care will minimize the consequences of noncommunicable or chronic diseases through early detection, prevention and quality care, and provide long-term palliative care for those with advanced disease. Such interventions would need to be supplemented by affordable long-term care for those who can no longer retain their independence. WHO has been supporting initial projects involving family health practitioners and primary health care providers who are looking at elderly health care in alignment with the relevant psychosocial and economic dependencies.

Development and progress have brought about improved quality of life. A key outcome has been longer life-expectancies among the Region’s populations. Longer life is associated with chronic diseases and disabilities in old age, not only affecting the overall quality of life but also as an emergent challenge for the family, the community and the national government. Traditional values and practices still occupy a key position where long-term care of the very old is concerned. However, the changing patterns of society where nuclear rather than the joint family is now becoming the norm and economic transitions where large rural-to-urban migration is taking place leaving the old and the infirm at home, are some of the issues affecting the age-old balance of care of the very old persons at home. WHO is concerned about this ever-increasing need for ensuring appropriate long-term care for very old persons, and it continues to interact with Member States on this subject. There is a need for a regional database on community and institutional facilities providing care for the aged populations and national legislation and laws to support and promote healthy ageing. These are issues that WHO has been emphasizing to its Member States. Research on the socio-epidemiological dimensions of healthy ageing; physiological and clinical issues related to ageing; and the technical competencies of national staff in geriatrics and gerontological issues, also requires urgent attention of Member States.

Building an age-friendly society requires action by a variety of sectors other than health and includes education, employment, labour, finance, social security, transportation, justice, housing and rural-urban development. All these sectors touch upon the scope of public health and the World Health Organization strives to work with these partners to develop policies and action that promote the health and health care of the elderly.

Dr Samlee Planbangchang
Regional Director
The World Health Organization’s definition of health and active ageing presents an interesting paradox for older people in the developing world. While WHO’s emphasis is on “continuing participation in social, economic, cultural, spiritual and civic affairs, (and) not just the ability (of the elderly) to be physically active or participate in the labour force”¹, for poor people growing old in low- and middle-income countries the continuing ability to work and remain productive is probably the single most important defining issue in active ageing. When older people are asked to name their key priorities, income security and health invariably top their list.

This is a recognition of the reality for older people in resource-poor situations that good (or at least adequate) physical and mental health is indispensable to their continued autonomy. Older people who become dependent on others have to share the hazards faced by their families and communities. Poor households have to make difficult decisions in sharing limited resources, and older people themselves will usually put a higher value on the needs of other family members than on their own.

Older people in developing countries would perhaps better recognize WHO’s stated position that those who are “…ill or live with disabilities can remain active contributors to their families, peers, communities and nations”. It is unusual for poor people to enter old age without chronic illness, disability or at least impairment. However this does not prevent them from continuing their active participation, whether through work or other community involvement.

Productive labour predominates for the “younger” old, in their fifties and sixties. However, the capacity of many older people for physical labour is progressively reduced, and their work is increasingly becoming low-level and poorly remunerated self-employment. Lifetime exposure to health hazards also has an impact on older people, especially the older poor, who contend with the “double

burden” of noncommunicable diseases such as hypertension, diabetes and cancer together with, for example, that of communicable diseases such as malaria and TB.

For many older people this situation is exacerbated by their lack of access to health services, which are often geographically remote and ill-prepared to respond to the needs of ageing population groups. Where health services are available, undiagnosed chronic conditions often lead to later and more costly treatment and care.

So does this situation mean that active ageing, which envisages allowing “older people to realize their potential for physical, social, and mental well-being throughout the life course and to participate in society”, is an impossible goal for older people in low-income countries? While the challenges are great, much can be done. For HelpAge the key lies with older people themselves. Starting nearly a decade ago, HelpAge’s six-country “Older Citizens’ Monitoring Project” assisted community groups to monitor the provision of local health services to older people2. The results in nearly all cases demonstrated a marked improvement in service quality and outcomes for older people.

From small beginnings this programme has developed into viable networks of older people’s groups across a large number of countries. HelpAge has helped establish nearly 5000 groups in recent years, in addition to those which exist with support from others, including (as in the case of Sri Lanka for example) national governments.

Many of these groups continue to identify healthy and active ageing as a significant objective and a large number run community activities to help their older members to stay healthy through exercise. Others operate home-care services, aiming to maximize the functional capacities even of home-bound older people. And, of course, older people regularly refer to the social, psychological and physical health benefits of being actively involved in the groups.

While addressing the “demand” side of active, healthy ageing is important, so too is the “supply” side. In this influencing health systems and especially the knowledge, skills and attitudes of health professionals is a key challenge. A growing body of opinion agrees that

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2 See for example HelpAge International: “Older Citizens’ Monitoring – the experience of Bangladesh”. HelpAge International 2009
health systems which have hitherto primarily been centred on the challenges of infectious diseases and maternal and child health will need to adjust progressively to respond to the conspicuous demographic transition and population ageing\(^3\) that is evident across the world. HelpAge has been actively involved with a number of institutional providers of pre- and in-service training for health professionals in the developing world, and has influenced curriculum development to encourage the inclusion of ageing and health. We believe that this will have important outcomes in the coming decades as these professionals progress through their careers.

We need to recognize that active and healthy ageing is not only with a focus on health services narrowly defined, but is concerned with the overall quality of life of the elderly. For older people this implies that we should address all the aspects of their lives which relate to their health and material security. As we have seen, this includes the need for a basic income, whether through the older person's own work or social security support, or a combination of both. It also requires attention to an enabling physical environment, and particularly to issues such as accessibility, affordability of transportation, and the like (to support this HelpAge promotes WHO's Age-Friendly Cities Initiative\(^4\)). Finally, health services need to be available and appropriate (to this end HelpAge promotes WHO’s Age-Friendly Primary Health Care Guidelines\(^5\)).

HelpAge International asserts that active and healthy ageing is an achievable goal, and one which requires interventions from all stakeholders, including governments, international agencies and civil society, to ensure that the goal is reached.

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\(^3\) Chen Jiagui et al: “Preparing for the challenges of population ageing in Asia”. Chinese Academy of Social Sciences, Indian National Science Academy, Indonesian Academy of Sciences, National Research Council (USA), Science Council of Japan, 2009, p21.


Over the past century, humanity has been adding years to life. More people are surviving childbirth and childhood, and adults are living longer than ever before. These are great triumphs. But they also lead to a predictable and accelerated ageing of populations around the world. In the next four decades, the proportion of people aged 60 and over in the global population is expected to rise from 10% to 22% – a jump from 800 million to 2 billion people. In developed countries such as Japan and Italy, the proportion will be nearer 40% of the population.

Less developed countries are experiencing most rapid ageing. In fact, they will only have very limited time to put in place the infrastructure and policies necessary to meet the needs of these very diverse populations. Perhaps they have only one generation to prepare their health and social systems for an ageing world.

Population ageing presents both challenges and opportunities. If no action were taken, population ageing may result in a shrinking workforce and an exponentially increasing demand for health care as well as social care and security. On the other hand, given good health and well-being, persons can continue to contribute to families, communities, cities and nations, in their ramified capacities as family members, leaders, workers, academics, scientists, artists, volunteers, advisers and caregivers well into old age.

Indeed, the longer older persons stay active, the longer they may enjoy good health and well-being and stay independent. The reverse
is also true: the longer they enjoy good health and well-being, the longer they can contribute and participate in society.

But this requires a paradigm shift, one that appreciates and enables older people to be active participants. We all – policymakers, practitioners, the media, civil society organizations and people across all generations and countries – need to change the way we think and act about ageing.

The World Health Organization (WHO) is enabling change through knowledge generation, innovation and transfer. WHO recommends the following interventions:

1. **Promote and live a healthy lifestyle across the course of life**

   Many of the health problems faced by older persons are the result of risk factors that arise during pregnancy and in childhood, youth and adulthood, such as smoking, lack of physical activity and unhealthy diets. Furthermore, maintaining an active lifestyle is one of the most cost-effective ways to stay healthy. An active lifestyle means older persons continue to participate in social, economic, cultural, spiritual and civic affairs, no matter what their level of physical functional ability might be.

2. **Create age-friendly environments and policies to engage older men and women**

   This area of interventions is about creating environments and policies that foster active and dignified ageing, allowing an older person to participate actively in family, community and political life - irrespective of their level of functional ability.

3. **Make primary health care age-friendly**

   While the goal of health care interventions is to suppress disease and disability until the very last years of life, it is inevitable that some persons at a later stage in life still experience significant functional problems. This means, we need to minimize the consequences of noncommunicable and other chronic diseases.
Older people are a precious resource for their families, communities and economies.

Elderly women have special health needs.
Ids life to years

Population ageing is a triumph of modern society

Age-friendly environments should be developed to encourage full participation by the elderly
through early detection, prevention and quality care while providing long-term and palliative care for those at an advanced stage.

If we are serious about building age-friendly societies everywhere, a range of sectors need to step up their actions in addition to the health and social sectors. Education, employment and labour, finance, housing, transportation, justice and rural and urban development all touch upon the scope of public health. World Health Day on 7 April 2012 is your opportunity to appreciate older persons’ contributions and showcase your contribution to make this an age-friendly world.
The proportion of the old and very old in the population is the fastest growing segment in most Member countries of the WHO South-East Asia Region. With higher longevity, exposure to known and unknown health risks is longer and the impact of biological decline of ageing is greater in later life. Consequently, older people carry a large burden of metabolic-vascular diseases, degenerative diseases of the brain, musculoskeletal and sensory systems, as well as exposure-related diseases such as cancer.

This proportion of morbidity requires easier access to quality primary and specialist health services, alongside adequate financial and human resources for old age care. Age-related diseases affect functional capacity, and various disabilities are commonly observed among older people. Societies across the world, including South-East Asia, are striving hard to put in place systems which would ensure better quality of life, autonomy and independence for older people.

Health systems in the Region have debated ways and means to ensure quality health service for older people without segregation from the mainstream. The concept of “dedicated geriatric service” is often considered a contradiction to the philosophy of integration of services. Some countries have finally reconciled to the fact that such dedicated services are necessary due to the
complexity of old age care. A busy primary care physician or specialist can rarely, if ever, carry out a detailed assessment and management planning in the face of limited training and time. The elderly have to compete with the rest of the population for services in view of the generally large populations and the limited facilities.

In recent years several countries have taken steps to improve services for older people. Thailand, Indonesia and India have identified geriatric medicine as a necessity in the health system. The Government of India launched an ambitious programme in its 11th Five Year Plan which proposes geriatric wards in eight regional medical institutions and a hundred district hospitals. The scheme also intends to extend services to the first point of contact with the community. In the 12th Five Year Plan, the scheme would reach all districts and all states in India. It also expects to stimulate the expansion of training facilities in geriatrics to raise the number of trained doctors and health professionals. While implementation of the Plan may take years, the acceptance of geriatric care as a distinct component of the health system is heartening. Similar initiatives are expected in other countries in the Region in the near future.

While the governments can provide health services, the care of the elderly is a responsibility of the family. Families still have the resilience to take care of its old and infirm despite lack of resources. Long-term care of the bed-bound elderly, especially in 80+ age-group, is a challenging task in view of the variable length and quantity of such care. It is more so if the patient has dementia or a paralytic disease. Even a frail elderly with intact cognitive capacity may need intense care. Three issues are of great importance in long-term care: i) assistance in activities of daily living, especially personal hygiene; ii) treatment of chronic diseases and disabilities; and iii) acute health problems which are often unanticipated and disturb the stability of the care mechanism.
In traditional South-East Asian societies, intergenerational relationships, caring, ill health, etc. are considered private issues and generally kept within the confines of the family. Thus, long-term care is mostly home-based. The family with or without paid help provides the physical care whereas the local general practitioner is the main source of medical care at the community level. In the Maldives there exists a provision for home visits from the Primary Health Centre for all home-care recipients.

As most hospitals in the Region cater to the acutely ill, older patients with less acute or chronic health problems find themselves as “misfits” or “neglected” in a hyper-dynamic acute-care hospital which is preoccupied with events and precision clinical procedures, deaths and bed occupancies, etc. Several countries elsewhere have experimented with institution-based care as the best option for long-term care, only to realize that it entails enormous economic costs. In most countries of the Region, nursing home-based long-term care is neither culturally appropriate nor affordable, and is thus practically non-existent.

Old-age homes are only sheltered accommodation for older people, without any nursing or health-care infrastructure. This concept is catching up as a matter of state policy in many countries in the Region as well as a preferred individual choice given the assured safety, security and service. The old-age home industry is mostly unregulated and there is a need for putting in place certain minimum standards. People with resources do not need sheltered accommodation or institutional care as they can pay for formal care at their homes. Poor and destitute persons who may need institution-based care cannot afford them. Long-term care has a price, and there is also a need for debate on its policy and best practice.
The demographics of population ageing are well known, but what is not known is the isolation and pathos in the life of the elderly. Population ageing is not about mere numbers but about individuals who are human beings full of warmth and emotions.

Karl Marx said, “If one person dies, it is a tragedy and if millions die it becomes mere statistics”. Therefore, the tragedy of individual isolation and state of destitution when extrapolated at the global level becomes a mere demographic detail. It will indeed be a tragedy if India, which has a strong commitment to the protection of human rights, allows the elderly in the country to be lost in the jungle of statistics. From this angle, I feel we ought to take a second look at the policies, legislation and programmes for the elderly in India.

I believe that ageing is a culture-related developmental issue. How the elderly are treated could be an acid test or measurement of the cultural level of a society.

By and large the elderly, if they are not economically protected, socially accepted and psychologically confident, see their lives reduced to an existence without motive, which is tantamount to a vegetative existence or social death. With their best years gone, companions departed and no one to share or care, many
of the elderly tend to consider themselves as chronic parasites of no use to society.

The steady increase in life expectancy and growth in population ageing can be seen as a success story of medical advancement and technology and sound public health policies. It also poses a challenge to society to adapt in order to maximize the health and functional capacity of older people as well as their social participation and security.

“Policy” as perceived by the United Nations is “a statement which includes long-term objectives and short-term goals and strategies to achieve them”. International policies do not consider the grassroots situation, therefore they often turn out to be a political statement with a diluted applicability. A national policy is usually a more realistic statement as it relates itself to the ground realities, and is cognizant of the felt needs of the people, based on applicability as well as accountability to the stakeholders.

The United Nations refers to ageing as a challenge and an opportunity, and a reflection of new thinking and emerging new policy response to population ageing in the 21st century. A major achievement at Madrid in 2002 at the Second World Assembly on Ageing, resulting in the Madrid International Plan of Action on Ageing, was that for the first time governments agreed to link questions on ageing to other frameworks for social and economic development and for human rights.

Ageing in India

After the Madrid International Plan of Action on Ageing, the Ministry of Social Justice & Empowerment of the Government of India, the nodal agency, announced the first National Policy on Older Persons in 1999 with a view to provide State support to ensure financial and food security, health care, shelter and other needs of older persons, an equitable share in
development, protection against abuse and exploitation, and to secure the availability of services to improve the quality of the lives of the elderly.

To achieve the above goals several initiatives have been undertaken by the Government of India and the state governments as well as at the local level, to provide services and create necessary infrastructure to improve the quality of life of the elderly.

The enactment of the Maintenance and Welfare of Parents and Senior Citizens Act, 2007, the training of geriatric personnel, advocacy, and formulating the Integrated Programme on Older Persons are some of these initiatives.

As a mandate to implement the National Policy on Older Persons (NPOP) of India, the Government of India set up the National Institute of Social Defence. The Institute provides and develops technical inputs and skilled personnel in the capacity of caregivers for the elderly. Research on various aspects of ageing and dissemination of information is also their mandate.

The NPOP can make a change in the lives of the elderly only if it is implemented effectively. While the government and its principal organs have some basic normative and monitoring responsibilities in the matter, other institutions and individuals will need to consider how they can play their respective roles for the well-being of elderly people. Collaborative action will go a long way to achieve a more humane society which gives older persons their legitimate place. Apex-level organizations of older persons (e.g. All India Senior Citizens Confederation, HelpAge India, International Longevity Centre-India, Dignity Foundation etc.) should participate in the process of policy drafting and formulation and be active partners in the projects and programmes for the senior citizens charted out by the government.

The NPOP of India has listed several objectives, such as the creation of a Commission; the establishment of a separate ministry/department for ageing; accountability to parliament; creation of a welfare fund for senior citizens; revision of the composition of the National Council of
Older Persons etc. These objectives are listed as things to be done, but if the implementing agencies or the budgetary allocations are not identified or provided, the policy is likely to reduce itself to a shopping list.

Nineteenth century policy prescriptions cannot be applied to 21st century realities. The global scope of the graying demographics is well known and is irreversible. These demographic trends will define our social and economic needs and government policy for decades. It requires a radical new way of thinking, which includes a 21st century approach to policies that align with the longevity revolution begun in the latter part of the 20th century.

The implications are dizzying. Asian countries will have to import health workers to take care of their elderly. Public pension plans will have to be re-examined to account for the millions of workers who will need retirement funds even as they continue to work into their 70s. The number of Alzheimer’s patients is expected to double every two decades and as longevity extends, insurance and retirement saving plans will need to be reconceived as ageing populations need to stretch benefits for longer periods.

To meet these challenges, comprehensive public health services need to be expanded and strengthened considerably. Geriatric care facilities need to be provided at secondary and tertiary levels too. Programmes on sensitization and inter-generational bonding need to be developed.

The focus will have to move away from the concept of treating population ageing as a socio-economic burden to one that will be productive and participatory. This can only be achieved when senior citizens become an active, contributing element to the development of society, participating in activities which are productive, rather than just being dependent on others.