Social dimensions of ageing and health

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Abstract
Population ageing is posing a challenge to health care and social security systems in many developing countries. The major issue is the impact of socioeconomic and psychological factors on the health of older people. With age, the socioeconomic disadvantage in health appears to accumulate making older people vulnerable. Inequities in health may get compounded by the effect of gender, nationality and ethnic status. A life-course approach addressing the health and economic needs of poor people and more accessible and affordable health service are conducive to promote active ageing. A change in the mindset that allows governments to perceive older people as resources and as partners in development rather than as “beneficiaries” would also help in formulating appropriate policies and programmes.

The proportion of older people is increasing in almost all countries of the world. This is due to population ageing — a demographic trend in which there is a decline in both birth rate and death rate in a population. With an increase in life expectancy, adults will continue to live to the “ripe” old age. Every society has mechanisms to provide for its ageing population. But the rapidity with which the older segment (60 + years and above) is growing is unprecedented. It took France 115 years to increase the percentage of elderly from 7% to 14% (1865-1980). In Japan this demographic transition occurred in just 26 years (1970-1996). Developing countries are taking still shorter time to increase their share of the elderly. For example, Jamaica will take 18 years, (2015-2033) to double its ageing population from 7% to 14%. In Tunisia it will be just 15 years (2020-2035). The number of elderly in the world is expected to touch one billion mark by 2020 (Atal, 2000)1. Population ageing will have a major impact on health-care expenditures, patterns of production and consumption, trends in labour market, social security measures and kinds of formal and informal care services. Most developing nations have not yet succeeded in putting appropriate economic, social and health-care systems in place to ensure quality of life of older people.

Quality of life at any age is influenced by financial security, emotional security and health. The most common domain cited in terms of disadvantage of the ageing process is “health”. As more people reach old age and live longer, access to affordable and appropriate health care becomes a dominant need. Health is a key factor in personal well-being and social development. Starting from the early 1950s the development of social epidemiology and medical sociology has transformed scientific and popular understanding of health and illness. There is a shift from a purely biological viewpoint to understanding the socioeconomic and psychological determinants of health (House, 2002)2. The conditions in which people are born, grow, live, work and age, add a social dimension to biological/genetic factors in health. Social circumstances, in turn, are shaped by local, national resources and their

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distribution, which are themselves influenced by policy choices. Inequities in social determinants lead to health inequities - the unfair and avoidable differences in health status seen within and between countries. Responding to the increasing concern about persisting and widening health inequities, the World Health Organization (WHO) established the Commission on Social Determinants of Health in 2005. In October 2011 in Brazil, The Rio Political Declaration on Social Determinants of Health was adopted during the World Conference on Social Determinants of Health. The declaration expresses global political commitment to reduce health inequities and to achieve other global priorities. It will help to build momentum within countries for the development of dedicated national action plans and strategies.

This WHO initiative to focus on the social dimensions of health has solid research backing. There is a large international literature concerned with the income-health connection that is more than five decades old. The first Whitehall study, begun in 1967, showed the relationship of socioeconomic status (SES) to mortality that persisted even after 25 years for both men and women (Marmot and Shipley, 1996)\(^3\). Inequalities within a single country and the relationship between aggregate inequality and population health across countries have been researched since then. Does wealth improve health? It appears so. Inverse association between socioeconomic status and health is the central finding from much research on the social determinants of health (House 2002)\(^2\). There is a well-documented but poorly understood “gradient” linking socioeconomic status to a wide range of health outcomes (Deaton and Paxson, 1998)\(^4\). This so-called “socio-economic gradient in health” has been observed across different time periods and age groups using a wide range of SES indicators, health measures and methodologies (Smith and Goldman, 2007)\(^5\). The relationship between socioeconomic status (SES) and health is well-established in Western industrialized countries. Individuals with lower SES experience higher rates of mortality and are more likely to suffer from multiple health problems. This trend is seen in studies conducted in the United Kingdom of Great Britain and Northern Ireland (Banks, 2007)\(^6\) and the United States of America (Schnittker, 2004)\(^7\). There exists a steep negative health gradient for men in both countries where men at the bottom of the economic hierarchy are in much worse health than those at the top. This social health gradient exists whether education, income or financial wealth is used as the marker of one’s SES status. Based on data from two national longitudinal surveys, Buckley et al.\(^8\) report a similar SES-health link in Canada (2005). In urban Mexico, Smith and Goldman (2007)\(^7\) found a similar pattern where higher education and affluence were associated with better health. The result from studies in Latin American cities also finds evidence of a SES gradient in SRH (self-reported health) and disability (PAHO, 2003)\(^9\).

The relationship between SES and health is less clear in developing countries. In a population-based cohort study in South India, people with low socioeconomic status (SES) had almost two-fold higher mortality rates across all age groups compared with people with high SES (Mohan and Muliyil, 2009)\(^10\). Several studies in Asia show that higher education and affluence are associated with better self-rated health and lower mortality, but that the association with functional limitations and chronic conditions is less consistent and generally weaker (for e.g. Zimmer et al. 2004)\(^11\). Similarly, a longitudinal study in a peri-urban area of Costa Rica finds that mortality tends to be lower among the more educated, but is not related to wealth (Rosero-Bixby, Dow, and Lacle, 2005)\(^12\). Though wealth impacts health, the relation appears complex (Hertzman, 1999)\(^13\). Above a particular income level, the health-wealth curve flattens out and increase in per capita income does not necessarily relate to increase in health status. Yet, the traditional SES-health

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relationship persists in poorer countries of the world. Despite its regularity, the slope of the gradient varies from country to country, suggesting that it is modifiable. The gradient, for example, is reported to be steeper in the United States as compared with the United Kingdom (Banks, 2007). Countries with relatively unequal income distribution tend to have steeper gradients in health status (Hertzman, 1999). The question: “Are people in poor health because they are poor or are they poor because of poor health?” is a complex one. Establishing the direction of causality is of both research and practical importance. A longitudinal-based research shows that the relationship between SES and health is particularly one of social causation (i.e. social position affecting health status) as opposed to the opposite (i.e. health selection).

Does the overall level of health inequality within a cohort change as people age? Will inequalities accumulate or even out? Answer to these questions are critical for developing countries struggling to respond to growing health needs of elderly with limited resources. Individuals with higher and lower SES may experience different health trajectories because of early life experiences and health behaviour. The cumulative effects of healthier living and other psycho-socio-economic advantages may postpone or compress morbidity and disability to a shorter period at the end of life. Alternatively, SES differences in exposure to risk factors may fade away among older adults. Exposure to extensive public welfare policies may reduce inequalities experienced by poorer adults. Beckett (2000) suggests that SES difference expands through the late middle age and declines thereafter. Prus (2007) however, reports that both SES and total health inequality increase hand in hand with age. Even in Canada with a well-established public health plan, SES differences in health increased with age for both men and women (Buckley, 2005). The magnitude of health inequalities in old age will depend on social welfare policies, cultural contexts and availability of familial or other social support.

The potential for healthy ageing hinges on economic resources in old age for poor people. To achieve postponement of disability and morbidity for all persons, welfare measures should focus on the poorest of the poor and at earlier stages of the life-course.

There is undoubtedly a strong link between income and health. Poorer people are more prone to lifestyles with enhanced risk factors. They usually have less access to health care, including preventative health care. Their personal and work environment may be unhealthy, even dangerous. Unemployment has adverse health consequences. With age, exit from the workforce, coupled with the rising cost of living, will reduce their economic resources. Increased demand and inequitable supply in socioeconomic and medical resources will add to the problem. The provision of medicare at older ages could mitigate the problem by making health care available to everyone. Comprehensive medical-social security cover for the entire population throughout the life-course is an ideal realized in practice in very few countries. Even in the United States, perceived by many developing countries as the fabled land of opportunity and success, there is a “crisis in ageing”. Poverty, age discrimination, rationing of health care, uncertain economy and private pension crises, made the American gerontologist Robert Butler ask a poignant question, “why survive?”

Little is known of SES-health link differences by sex in developing countries. Gender significantly influences many variables related to quality of life. In all societies, women constitute a larger proportion of the poor and they lag behind men in almost every social and economic status indicator (Cohen 1998). On average, women live seven to eight years longer than men. However, older women experience more chronic illnesses and functional impairments, report more depressive symptoms, experience higher levels of psychological distress, and have higher rates of prescription drug use than do older...
men. Gender roles influence the type and amount of social support received by older women. Widowhood, economic dependence, rural background and cultural-social restrictions affect women’s lives adversely (Prakash, 2010). Research on sex differences in the SES-health relationship has been mixed. There are studies reporting the gradient to be similar, reversed, and even absent (Smith and Goldman, 2007). Inverse association of literacy status with all-cause mortality was observed in older Indian men and women, while, for CVD mortality it was observed only in men (Pednekar, et al. 2011). Mutaner et al. (2003) found social class indicators less useful as correlates of health and mental health among Spanish women than in men. Liang et al. (2000) observed the gender (by SES interaction) effect on old age mortality in China and recommended improving education among women as a high priority for policy-makers.

The role of non-economic factors such as gender, race and ethnicity cannot be ignored as they impact health and wealth in many ways. Health differences in different SES groups are not only due to material (resources) differences but also due to personal, cultural and lifestyle differences. Material factors are the direct effects of SES on health, while lifestyle and psychosocial factors are the indirect effects. Those with higher education, for example, tend to have higher occupational status and earnings and, thus, adequate financial resources to support the purchase of good housing, nutrition, and private health care, all of which are directly tied to better health. SES also influences health indirectly, as position in the socioeconomic structure affects psychosocial (e.g. negative life events, chronic stressors, coping skills, and social support) and health-related lifestyle preferences and behaviours (e.g. smoking, drinking, exercise, acquisition/interpretation of health-education information), which in turn affect health. Research supports a holistic approach to health that takes into consideration social support and personality factors.

and networks are increasingly recognized as important determinants of health in elderly (Stoddart et al. 2010). Psychosocial factors are often ignored in health research. The social support network protects against harm and promotes emotional and physical well-being. Lachman and Agrigoroaei (2010) identify modifiable psycho-social and physical factors that are protective in nature, influencing the functional health of the elderly. Feelings of loneliness and isolation affect older adults’ health in a number of ways. They can create stress, lower self-esteem or contribute to depression, which may have physical health consequences. One’s personality can influence the SES health gradient in two ways. It may mediate the association between social class and health or it is possible that personality differences may actually produce social class differences. Understanding this link requires research collaboration between psychologists and epidemiologists.

**Implications for policies and programmes**

Obviously, the SES gradient in ageing and health is more complex than it appears. Whatever the explanations and theories regarding this phenomenon, the bottom line is that older people who are poorer are more vulnerable and face higher morbidity and mortality risks. It is undisputed that population ageing will throw up several challenges to all societies. But its magnitude and manifestations are not the same everywhere. The level of development, existing policies and several political and cultural factors will determine to what extent the challenge will become a problem. As such there cannot be a single strategy for dealing with these problems, but there can only be a common commitment (Atal 2000). Governments are also aware that a more equitable distribution of resources and equity in providing services needs to be achieved. Improving the socioeconomic position of disadvantaged strata has been the agenda of many governments. The United Nations, the World Health Organization and
the Pan American Health Organization documents have repeatedly stressed the need to ameliorate the basic inequalities in societies to address the needs of the elderly. Obviously more has to be done with greater focus, consistency and intensity. How countries will generate additional resources and strategies to overcome existing inequalities will depend on political will and careful planning.

Needless to say, reduction in poverty and illiteracy levels forms the basis for improvement. Special care has to be taken to address the special needs of vulnerable groups such as women, and the frail, disabled and ethnic minorities. The widening health gap observed between SES groups suggests that policies of income redistribution should be targeted at the lowest SES groups. Governments should strive to make equal access to services and health care a reality. Dunlop et al. (2000)26 find that patients’ utilization of specialist visits is greater for those in the higher socioeconomic groups. Perception of medical care as unaffordable, cost of transportation, and loss of work are factors that often prevent poor people from accessing health care. Strengthening primary health-care services and integrating geriatric services in local centres is one way to ensure that health needs of the elderly are adequately met. The SES gradient in health is seen to be sensitive to social conditions. Governments need to work to reduce the overall levels of income- and education-based health inequality.

There is some consensus that health inequalities tend to increase with age, which in turn is associated with SES levels. This would suggest that to postpone morbidity and disability, measures should be targeted towards low SES groups. In the earlier life stage itself, the poorest of the poor need to receive financial support and health interventions to overcome their disadvantage that is cumulative. The expansion in the gap in longevity and health coincides with lifestyle problems such as relative increase in obesity, smoking and alcohol consumption, etc. In some countries like India, undernutrition as opposed to obesity, may be more of a risk factor for mortality in the older cohort. Health promotion policies, programmes and services aimed at modifying the rates of obesity, exercise, stress, poor diet and drug use, etc. should also be responsive to the needs of lower SES persons.

Physical and emotional isolation is a high-risk factor negatively affecting the health and well-being of older persons. Adequate social support, both emotional and instrumental, can have positive health-relevant effects. Voluntary organizations, community-based organizations (CBOs) and nongovernmental organizations (NGOs), and local senior clubs could be effectively used to enhance social support for the elderly, especially those living alone. There is also some evidence that those with better education are more likely to follow medical advice (that is, to have better treatment adherence) and hence to benefit more from health education and health promotion programmes. Without doubt, literacy is an empowering tool. Even in communities with low rates of literacy, adult literacy programmes with emphasis on health education and lifestyle modification could be implemented. Nongovernmental organizations could be used effectively for this purpose. In particular, improving education among women in underdeveloped areas must remain a high priority for policy-makers.

Policies and programmes need to be based on sound data from reliable sources. Multidisciplinary research to identify indicators of health inequality and preventive and protective factors would help formulate more effective policies and programmes. Similarly, SES differences in health behaviours later in life, that may act as buffers or risk factors, need to be well researched. Understanding which social conditions exacerbate health inequality would help to identify indirect paths from policy to health inequality. Deaton27 suggests (2002) that if certain patterns of
economic growth exacerbate health inequalities, policy could be directed towards altering the pattern (not necessarily the pace) of economic growth. Or, if increase in income inequality across many advanced industrial countries is associated with higher levels of health inequality, then a case could be made for efforts at income redistribution. Periodic evaluation to demonstrate the effectiveness of certain policy innovations and programmes would provide useful feedback.

Ensuring independence, care, participation and dignity to the growing millions of older people is not an easy task, nor should it be sidelined in developmental programmes. It should be acknowledged that ageing is a multidimensional process of interaction among multiple domains – biological, social, cultural, economic and psychological. A paradigm shift from viewing ageing as a problem, to viewing it as another life phase with opportunities for development is more conducive to active ageing programmes. A change in the “State doling out to older beneficiaries” approach to “old people as a resource” should guide policies. As Kaplan and Berkman (2011) 28 rightly state, it would be a folly to focus on health alone without consideration for the social environment, or mobilize essential services without assessing or addressing the perceptions of the older people. Hence, involving older people in all programmes and the policy-decision process as participants is essential to achieve equity in health care.

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