Indian Journal of Hygiene and Public Health
Publication of All India Institute of Hygiene & Public Health, Kolkata.
ISSN : 2455-1813

Editorial

Ageing and Public Health

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For the first time in the history of humanity, most people can expect to live into their 60s and beyond. This is largely the result of large reductions in mortality at younger ages, particularly during childhood and childbirth, and from infectious diseases.
These trends are largely predictable. The demographic transition to older populations is bound to take place, and we need to anticipate and plan for it.[1]

Chronic diseases account for most of the health problems of older age. Healthy behaviours can prevent or delay many of these diseases. Physical activity and good nutrition can have powerful benefits for health and wellbeing even in older age. Other health problems, if they are detected early enough, can also be effectively managed,.

Since 2002, two international policy instruments: the *Political declaration and Madrid international plan of action on ageing*[2] and the World Health Organization's *Active ageing: a policy framework*[3] have guided action on ageing.

A recent review of the progress made globally since 2002, noted that "there is low priority within health policy to the challenge of the demographic transition"; "there are low levels of training in geriatrics and gerontology within the health professions, despite increasing numbers of older persons"; and "care and support for caregivers…is not a priority focus of government action on ageing".[4]

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In lower-income countries, access to health services is often limited. Health workers may have little training in how to deal with issues common in older age, such as dementia or frailty, and opportunities for the early diagnosis and management of conditions, such as high blood pressure (a key risk factor for the biggest killers of older people – heart disease and stroke), may be missed. A comprehensive, global public-health response to population ageing will therefore need to transform systems that are fundamentally misaligned with the populations they increasingly serve.

There are many justifications for devoting public resources to improving the health of older populations. The first is the human right that older people have to the highest attainable standard of health. The second key justification for taking action on ageing and health is to foster sustainable development.[1]

With increasing age, numerous underlying physiological changes occur, and the risk of chronic disease rises. By age 60, the major burdens of disability and death arise from age-related losses in hearing, seeing and moving, and noncommunicable diseases, including heart disease, stroke, chronic respiratory disorders, cancer and dementia.

Moreover, since ageing is also associated with an increased risk of experiencing more than one chronic condition at the same time (known as multimorbidity), it is simplistic to consider the burden from each of these conditions independently. The impact of multimorbidity on an older person's capacity, health-care utilization and their costs of care is often significantly greater than might be expected from the summed effects of each condition.[1]

Healthy Ageing is the process of developing and maintaining the functional ability that enables well-being in older age**.** Numerous entry points can be identified for actions to promote *Healthy Ageing*, but all will have one goal: to foster functional ability This can be achieved in two ways: by supporting the building and maintenance of intrinsic capacity, and by enabling those with a decrement in their functional capacity to do the things that are important to them.
Unfortunately, although there is strong evidence that older people are living longer, the quality of life during these extra years is quite unclear.[1]

ADLs are used in many settings as indicators of eligibility for care services and they are likely to reflect a significant need for care. This need for assistance ranges from around 17% of people

75 years and older in Switzerland to well over 40% of people of the same age in Ghana, India, Mexico and the Russian Federation. Many of the countries with the highest need also have the least infrastructure and services in place to address this care dependence and default to relying on families to provide care.

As most of the disease burden in older age is due to non-communicable diseases, risk factors for these conditions are important targets for health promotion. Strategies to reduce the burden of disability and mortality in older age by enabling healthy behaviours and controlling metabolic risk factors can therefore start early in life and should continue across the life course.

Unprepared health workers

Health professionals are often unprepared to deal with the health-care needs of older adults. Many current training approaches were developed in the 20th century, when acute infectious diseases were the world's most prevalent health problems. As a result, health workers are trained primarily to identify and treat symptoms and conditions using an episodic approach to care. This does not prepare them well for the holistic perspective that has been shown to be most effective when caring for older people, or to controlling and managing the consequences of chronic conditions in ways that fit with an older person's priorities.

Furthermore, although most patients within health systems are older, curricula frequently overlook gerontological and geriatric knowledge and training, and may lack guidance on managing common problems, such as multimorbidity and frailty.[1]

Although the world is experiencing a rapid transition towards ageing populations, health systems generally have not kept pace. Most health services around the world have been designed around acute care models that are poorly aligned with the dominant health issues of older age. This failure in care is exacerbated by age-based discrimination and by ignorance of the priorities and needs of older people. New approaches are needed to foster *Healthy Ageing*.

Evidence suggests that the best way to design systems to better meet the needs of older people is by placing them at the centre of service delivery. Evidence suggests that focusing primarily on older people's intrinsic capacity is more effective than prioritizing the management of specific chronic diseases.[1]

To fill the roles needed, health workers will require several key competencies. They need to be able to perform basic screening to assess functioning, including vision, hearing, cognition, nutritional status and oral health, and they need to be able to manage health conditions that are common in older people, such as frailty, osteoporosis and arthritis. They should understand how depression, dementia and harmful alcohol use typically manifest in older people, and they should know how to identify neglect or abuse. Additionally, health workers should be able to conduct *Healthy Ageing* assessments and plan care because these are key tools for implementing older-person centred and integrated care. Beyond these specific competencies, health workers need more general competencies in communication, teamwork, information technology and public health.

Although transforming health systems requires action on several fronts, three key themes emerge as priorities:

- shifting the clinical focus from disease to intrinsic capacity;
- rebuilding health systems to provide more person-centred and integrated care to older people;
- transforming the health workforce so that it can better provide the care that these new systems will require.

For most older people, the maintenance of functional ability has the highest importance. The greatest costs to society are not the expenditures made to foster this functional ability, but the benefits that might be missed if we fail to make the appropriate adaptations and investments. The recommended societal approach to population ageing, which includes the goal of building an age-friendly world, requires a transformation of health systems away from disease-based curative models and towards the provision of integrated care that is centred on the needs of older people.

Social factors

Since care dependency increases with age, population ageing will dramatically increase the proportion and number of people needing social care in countries at all levels of development. This will occur at the same time as the proportion of people at younger ages who might be available to provide this care will be falling, and the role of women, who have until now been the main care providers, is changing.

Ageism is the stereotyping of and discrimination against individuals or groups based on their age. Ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical beliefs.[1]

Even in India, a country where strong family ties have often been assumed to continue, only 20% of households include people living in joint or extended families. Tensions are rising in many countries as younger generations feel either less reason to, or have a reduced ability to, fulfil filial duties. The rise of smaller families and the increase in migration for work often mean that fewer children are at home to share physical, emotional and financial responsibilities for ageing parents and grandparents. This has the potential to lead to social exclusion, isolation, poverty and even abuse of older people, and an increasing mismatch in intergenerational expectations.[1]

Population Ageing in India: Facts, Issues, and Options

In India, the population share of adults 60 and up grew from 5.4% in 1950 to 9% today in absolute number of individuals, this represents an almost six-fold increase, from 20.3 million in 1950 to more than 116 million today. Under a medium-fertility scenario, the United Nations Population Division projects that adults 60 and over will comprise 19% of India's total population by 2050. Currently, the growth rate of the number of older individuals (age 60 and older) is three times higher than that of the population as a whole.[5]

As India's population structure changes, so does its health profile. This is especially true for non-communicable diseases (NCDs). NCDs include cardiovascular diseases, cancers, chronic respiratory diseases, diabetes, and eyesight conditions, the prevalence of which all increase with age. While infectious, nutritional, maternal, and perinatal conditions have traditionally represented the greatest health threats in India, the country now faces a "triple burden of disease" comprising both infectious and chronic conditions and violence and injury.

One of the most important implications of an increasingly female older adult population in India—including variations in the extent of this trend across states—will be the higher prevalence of widowhood among women.

The Ministry of Health & Family Welfare launched the Longitudinal Ageing Study in India (LASI) in 2016. The study will provide valuable data on their health needs, and issues faced by them given the changing social structures, and help us to draw policy tools to address their issues. The study will be important as it will investigate various health structures, and impact of social determinants on health of the elderly. It will also help in framing evidence-based policy.[6]

The growth of the elderly population in the coming decades will bring with it unprecedented burdens of morbidity and mortality across the country. The key challenges to access to health for the Indian elderly include social barriers shaped by gender and other axes of social inequality (religion, caste, socioeconomic status, stigma). Physical barriers include reduced mobility, declining social engagement, and the limited reach of the health system. Health affordability constraints include limitations in income, employment, and assets, as well as the limitations of financial protection offered for health expenditures in the Indian health system.[7]

SAGE India has collected data on five major factors that increase or reduce the risk of certain health conditions: tobacco use, alcohol consumption, intake of fruits and vegetables, physical activity levels, and environmental risk factors such as access to improved drinking water and improved sanitation facilities and the type of fuel used for cooking. The major findings are as follows. Tobacco use among older Indians is high. Alcohol use among older Indians is low. Older Indians are not eating enough fruits and vegetables. Older Indians are reasonably active.[8]

Ageing related programmes and policies in India

Article 41 of the Directive Principles of state policy in the Constitution of India says that "The state shall, within the limits of its economic capacity and development, make effective provisions for securing the right to work, to education and to public assistance in cases of unemployment, old age sickness and disablement, and in other cases of undeserved want." Social security is the concurrent responsibility of the central and the state governments. Other sections of the Constitution focus on labour welfare, including conditions of work, provident funds, liability for worker's compensation, invalidity (i.e. disability), and old age pension and maternity benefits (Article 42).

Taking into consideration the challenges posed by the rising ageing population, the various ministries of the Government of India, including the Ministry of Health and Family Welfare, the Ministry of Social Justice and Empowerment, and the Ministry of Rural Development, have initiated a number of policies and programmes for older populations.

In the 1990s, the Ministry of Rural Development initiated two important programmes to improve the economic security of very poor older adults, the National Old-Age Pension Scheme (NOAPS) and the Annapurna Scheme. Under the NOAPS, adults aged 65 or more who are destitute, in the sense of having no regular means of subsistence through individual income or through financial support from family members or other sources, are eligible for an old age pension of Rs. 200 per month, paid by the central Government. Under the Annapurna Scheme, indigent adults aged 65-plus who, although eligible for an old age pension under the NOAPS, but are not receiving the pension receive 10kgs of food grains per person per month free of cost.

In 1999, the National Policy on Older Persons (NPOP) assured older persons that "their concerns are national concern and they will not live unprotected, ignored or marginalized. It aims to strengthen their legitimate place in society and help older persons to live their last phase of life with purpose, dignity and peace." The policy visualizes that the state will extend support for financial security, health care, shelter, welfare and other needs of older persons, provide protection against abuse and exploitation, make available opportunities for the development of their potential and provide services so that they can improve the quality of their lives.

In 1999, the Ministry of Social Justice and Empowerment, commissioned a national project called OASIS (Old Age Social and Income Security) to examine the policy questions associated with old age income security in India. The project report recommended the formation of a National Senior Citizens Fund for encouraging,

catalysing and complementing private sector efforts for the betterment of life of senior citizens in the country.

Another major policy was initiated in 2007, when the Parliament of India passed the *Maintenance and Welfare of Parents and Senior Citizens Act 2007*, which permits older people to make an application against not only their children, but also any relative currently in possession of or slated to inherit their property, for support sufficient to permit them to lead "a normal life".[8]

In 2011, the Ministry of Health and Family Welfare initiated geriatric care policies and programmes in selected hospitals and rural health facilities.

National Programme for the Health Care for the Elderly

The National Programme for the Health Care for the Elderly (NPHCE)[9] is an articulation of the International and national commitments of the Government as envisaged under the UN Convention on the Rights of Persons with Disabilities **(UNCRPD),** National Policy on Older Persons **(NPOP)** adopted by the Government of India in 1999 & Section 20 of "The Maintenance and Welfare of Parents and Senior Citizens Act, 2007" dealing with provisions for medical care of Senior Citizen.

The Vision of the NPHCE is:

- To provide accessible, affordable, and high-quality long-term, comprehensive and dedicated care services to an Ageing population;
- Creating a new "architecture" for Ageing;
- To build a framework to create an enabling environment for "*a Society for all Ages*";
- To promote the concept of *Active and Healthy Ageing*;
- Convergence with National Rural Health Mission, AYUSH and other line departments like Ministry of Social Justice and Empowerment.

Specific Objectives of NPHCE are:

- To provide an easy access to promotional, preventive, curative and rehabilitative services to the elderly through community based primary health care approach
- To identify health problems in the elderly and provide appropriate health interventions in the community with a strong referral backup support.
- To build capacity of the medical and paramedical professionals as well as the care-takers within the family for providing health care to the elderly.
- To provide referral services to the elderly patients through district hospitals, regional medical institutions

Core Strategies to achieve the Objectives of the programme are:

- Community based primary health care approach including domiciliary visits by trained health care workers.
- Dedicated services at PHC/CHC level including provision of machinery, equipment, training, additional human resources (CHC), IEC, etc.
- Dedicated facilities at District Hospital with 10 bedded wards, additional human resources, machinery & equipment, consumables & drugs, training and IEC.
- Strengthening of 8 Regional Medical Institutes to provide dedicated tertiary level medical facilities for the Elderly, introducing PG courses in Geriatric Medicine, and in-service training of health personnel at all levels.
- Information, Education & Communication (IEC) using mass media, folk media and other communication channels to reach out to the target community.
- Continuous monitoring and independent evaluation of the Programme and research in Geriatrics and implementation of NPHCE.

Supplementary Strategies include:

- Promotion of public private partnerships in Geriatric Health Care.
- Mainstreaming AYUSH – revitalizing local health traditions, and convergence with programmes of Ministry of Social Justice and Empowerment in the field of geriatrics.
- Reorienting medical education to support geriatric issues.

Expected Outcomes of NPHCE

- Regional Geriatric Centres (RGC) in 8 Regional Medical Institutions by setting up Regional Geriatric Centres with a dedicated Geriatric OPD and 30-bedded Geriatric ward for management of specific diseases of the elderly, training of health personnel in geriatric health care and conducting research;
- Post-graduates in Geriatric Medicine (16) from the 8 regional medical institutions;
- Video Conferencing Units in the 8 Regional Medical Institutions to be utilized for capacity building and mentoring;
- District Geriatric Units with dedicated Geriatric OPD and 10-bedded Geriatric ward in 80-100 District Hospitals;
- Geriatric Clinics/Rehabilitation unit**s** set up for domiciliary visits in Community/Primary Health Centres in the selected districts;
- Sub-centres provided with equipment for community outreach services;

- Training of Human Resources in the Public Health Care System in Geriatric Care.

Package of Services under NPHCE

In the programme, it is envisaged providing promotional, preventive, curative and rehabilitative services in an integrated manner for the Elderly in various Government health facilities. The package of services would depend on the level of health facility and may vary from facility to facility. The range of services will include health promotion, preventive services, diagnosis and management of geriatric medical problems (out and in-patient), day care services, rehabilitative services and home based care as needed. Districts will be linked to Regional Geriatric Centres for providing tertiary level care.
The services under the programme would be integrated below district level and will be integral part of existing primary health care delivery system and vertical at district and above as more specialized health care are needed for the elderly.

Conclusion

The response of the society to population ageing needs a transformation of health systems moving away from disease-based curative models towards the provision of older-person-centred and integrated care. Comprehensive systems of long-term care need to be developed. A coordinated response from many other sectors and multiple levels of government is essential.

There must be a fundamental shift in our understanding of ageing. The diversity of older populations and the inequities that underlie ageing need to be taken into account. There is also need to develop better ways of measuring and monitoring the health and functioning of older populations.

Current public-health approaches to population ageing have clearly been ineffective. The health of older people is not keeping up with increasing longevity. Glaring health inequities are observed in the health status of older people. The health systems are not aligned to the needs of the elderly. Long-term care models are both inadequate and unsustainable. There are multiple barriers and disincentives to both health and participation in the physical and social environments.[1]

A new framework for global action is required. It will need to encompass the great diversity of older populations and address the inequities that lie beneath it. New systems for health care and long-term care that are more in tune with the needs of older people need to be developed, and all sectors need to focus on common goals so that action can be coordinated and balanced. We need to discard outdated ways of thinking about ageing, transform our viewpoint as regards ageing and health, and we need to implement evidence-based health system modifications.

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