

Epidemiological Change and Health Policy for Older People in Developing Countries: Some Preliminary Thoughts

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Abstract

This short paper assesses patterns of epidemiological change associated with population ageing in developing countries. It then considers how health policies in such countries have sought to meet the challenges posed by these changes.

The epidemiology of population ageing

The developed world has gone through an epidemiological or health 'transition' similar to, and associated with, the demographic one. This has seen the main causes of death and illness shift from infectious diseases, under-nutrition and inadequate hygiene to a post-transition phase, where 'diseases of wealth' (including chronic disease, road accidents and stress) are now prominent (Caldwell, 1993; World Bank, 1993). Most developing countries are experiencing similar trends, although the pattern can be variable and complex. Some authors refer to a process of 'incomplete transition' or 'epidemiological polarisation' (Frenk *et al*, 1991). On the one hand, easily preventable diseases and poverty-related problems still account for a high share of mortality and morbidity. On the other, emerging 'diseases of wealth' have seen rapid increases. Often, distinct epidemiological scenarios can be identified between different geographical zones (rural/urban; rich/poor regions) and between different socio-economic groups. As such, many developing countries face a double health challenge.

Given these different epidemiological settings, it is hard to predict the health needs of the swelling elderly cohorts in the South, and it should not be assumed that the health profiles of their older populations will match those of the North. In the North there is still disagreement about whether increased longevity means an extension of healthy active lives or an extension of morbidity (Fries, 1980; Sidell, 1995; Manton *et al*, 1997). In poorer countries, the data scarcely allow for an informed debate. Information about mental health and cognitive functioning is particularly limited (Desjarlais *et al*, 1995).

One developing country for which data on the health status of older people are relatively complete is Thailand. Table 1 summarises the findings of a national survey of 7,700 older people conducted in 1995. It reveals a pattern of disease which is similar to that of many developed countries, dominated by chronic conditions rather than infectious

disease. It demonstrates higher levels of disease prevalence for women and for people in rural areas. The survey data refer to self-reported health, which may under-state the true extent of health conditions, particularly where respondents do not have good access to diagnostic services, such as in rural areas. Access issues may be especially significant for older people, who may also be inclined to misdiagnose their ailments in terms of old age, rather than as health-related.

Table 1. Self-reported disease prevalence among Thais aged 60 and over (per cent), 1995

	Urban		Rural	
	Male	Female	Male	Female
Hypertension	19	30	13	17
Osteoarthritis	13	24	13	18
Heart disease	8	12	4	9
Diabetes	11	13	2	5
Stroke	6	3	2	1

Source: Chayovan & Knodel (1997).

The Thai survey did not ask older people about mental health, but did include a general question about loneliness, finding that 12 per cent of respondents reported they were very lonely. Separate smaller-scale surveys found that between a fifth and a third of older people presented depressive symptoms, and that dementia affected around three per cent of over 60 year-olds (Jitapunkul & Bunnag, 1998).

With regard to ADLs, the 1995 national survey found that 19 per cent of elders had experienced at least one fall in the preceding month, that 16 per cent had problems walking around the house, and that 66 per cent had some form of visual impairment. A separate survey of urinary incontinence found high levels of prevalence among elders (16 per cent). More than half of respondents in the survey reported that this condition had a significant psychological impact, and 8 per cent reported that their social lives were severely affected (Jitapunkul & Bunnag, 1998).

The fragmentary evidence suggests that Thailand's epidemiological situation roughly resembles that of other

middle-income countries in Asia and Latin America (Ham-Chande, 1996; Kai Hong, 2000; Vassallo & Sellanes, 2001; Lima-Costa *et al*, 2003). However, it is less likely to resemble that of low-income countries, where the impact of infectious disease, including HIV/AIDS, along with under-nutrition, may be much greater.¹ A survey of mortality patterns in Africa found that the leading causes of death for people aged 65 and over were diseases of the circulatory system (accounting for 41 per cent of deaths); infectious and parasitic diseases (19 per cent) and cancers (9 per cent) (World Bank, 1994b, cited in McIntyre, 2004). These are rough estimates, and do not give a direct insight into patterns of ill health among surviving older people. WHO is currently engaged in constructing a minimum data set on health and ageing for a number of sub-Saharan African countries, but is yet to publish epidemiological data.

Despite the evident dangers in generalisation, WHO has made a number of predictions about the impact of population ageing on global health. It projects that by 2020 three-quarters of all deaths in developing countries will be related to old age. Most of these will be caused by diseases related to the circulatory system, cancers, hypertension and diabetes (WHO, 1998). For example, current WHO projections show the prevalence of diabetes will increase by 160% in Africa and South-East Asia between 2000 and 2030. In India alone, it is predicted that there will be almost 80 million people living with diabetes by 2030. Systematic disaggregated data are not widely available for the prevalence of chronic disease among older people, but they are certain to bear a disproportionate share of the burden of most forms of chronic disease.

While population ageing is one factor in the increase of chronic conditions, other factors relating to consumption patterns and lifestyle changes may be more significant. Hence the impact of population ageing on chronic disease is not inevitable. According to WHO:

The modifiable risk factors for chronic conditions such as heart disease, cerebrovascular disease, diabetes, HIV/AIDS, and many cancers are well known. Lifestyle and behaviour are *primary* [author's emphasis] determinants of these conditions with the potential to prevent, initiate, or advance these problems and their associated complications (WHO, 2004, p. 1).

This raises key issues about health promotion for managing the potential pressures of population ageing on health systems.

A second important area of chronic disease relates to mental health. It has been estimated that two of the more common forms of mental illness (depression and anxiety disorders) account for between 20 and 30 per cent of primary care visits worldwide (Desjarlais *et al*, 1995). Little attention has been paid to mental health in developing countries, either for older people or the population in general. In part, this is due to a historical tendency to focus on infectious diseases and conditions more directly associated with mortality. In

some settings, mental health disorders may be perceived and understood in non-medical terms, such as bewitchment (Ferreira & Makoni, 2002). Despite a lack of robust prevalence data, there are good reasons for assuming that the extent of mental health problems is growing in the South. Several disorders are associated with or exacerbated by stress and environmental factors, which in turn will be influenced by processes associated with rapid change, modernisation and economic crisis. Older people are likely to be especially vulnerable to increased isolation and alienation as a result of such processes, leading to depression and anxiety (Van Der Geest, 2004).

Some mental health disorders, notably dementia, are closely associated with later life. Studies from around the world show that the prevalence of dementia usually doubles with every five year increase in age from around 60 to 90 years old. However, there is disagreement about whether the absolute levels of prevalence vary between countries. Surveys from the UK show levels of around 6.5 per cent for those aged 65 and over, compared to only 1.8 per cent in Singapore (Desjarlais *et al*, 1995). Whatever the current levels of prevalence, rapid population ageing will lead to a surge in dementia for most developing countries. WHO calculates that the number of people affected by senile dementia in Africa, Asia and Latin America may exceed 55 million in 2020 (WHO, 1998).

Distinguishing between health and disability issues in later life is not always straightforward. One area of overlap is visual impairment and blindness, which are particularly prevalent among older people in the South. In 1990 it was estimated that there were 38 million blind people globally, and a further 110 million had low vision and were at high risk of becoming blind (Thylefors *et al*, 1995). Of these, a disproportionate number (58 per cent) were aged over 60 years. This imbalance was particularly noticeable in developing countries, which accounted for 88 per cent of all the blindness in the age group. Age-specific prevalence rates show that levels of blindness will increase sharply over the decades to come, unless appropriate policies are developed. The majority of cases are caused by cataracts, for which cheap and effective treatment is available.

While the current state of knowledge about the effects of demographic ageing on population health remains fragmentary and somewhat speculative, it is clear that they will be significant and pose serious challenges to health care systems in developing countries. Many of these health care systems have patently failed to meet the health needs of younger population structures. The next section considers how health policy thinking has responded to this new challenge

Health policy for older people in developing countries

Health policy for older people in developing countries hardly features in most global health policy debates and forums

(Lloyd-Sherlock, 2002). The World Bank's *Averting the old age crisis* makes virtually no reference to the health care needs of older people (World Bank, 1994). One year previously, in 1993, the World Development Report (the Bank's flagship annual publication) bore the title *Investing in health* (World Bank, 1993). This report has been extremely influential on health sector reform policies across the developing world, but makes no reference whatsoever to older people. The most recent substantial World Bank publication on global health policy, which forms part of the 2004 World Development Report, makes virtually no reference to older people.² The World Bank is not alone in over-looking the health needs of older people in the South. The attention paid to the issue by organisations such as WHO and ILO, as well as most international NGOs and bilateral agencies has been minimal.

The needs of older people have been either excluded from or marginal to all the main international health policy initiatives applied in the developing world over the past half century. In the decades following the Second World War and the start of decolonisation, policy was dominated by ambitious programmes to control or eradicate various types of infectious disease, such as smallpox, polio and malaria (Dowdle, 1998). This was paralleled by the development of highly technical, western-curative hospital infrastructures, which were expensive but typically only reached a small minority of the population. By the 1970s, concerns about the high cost and doubtful efficacy of 'disease palace' hospitals which mimicked those of the North led to the emergence of primary health care as a major international health doctrine (Abel-Smith, 1994). This emphasised health promotion and prevention, basic services and universal access. While providing for older people became a central focus of primary health care in the North, its application in the developing world was almost exclusively concerned with mothers and young children.

During the 1990s two new key global health initiatives came to prominence: reproductive health care and health sector reform (Lane, 1994; Cassels, 1995; de Jong, 2000). Virtually no attention has been paid to reproductive health for older people, even though there are numerous ways in which reproductive health care directly affects their lives. Older people are more likely to remain sexually active than is often thought, and their situation in later life can be strongly influenced by reproductive experiences through the life-course.³ At the same time, health sector reforms sought to reorganise the financing and management of health services in order to promote efficient resource use. Despite the inevitable impacts of such reforms on groups such as older people, virtually no attention has been paid to the issue by either academics or policy-makers.

More recently the focus of international health policy has evolved in a number of ways. It has been recognised that greater coordination is required across the health sector.

This is especially important in low-income countries where state programmes typically exist alongside a plethora of smaller short-term projects funded by different NGOs and bilateral organisations (Buse & Walt, 1997). Second, more emphasis is being placed on ensuring that health programmes in low-income countries reach the poorest. These concerns have given rise to a variety of new initiatives, including Sector-Wide Approaches (SWAPs) and Poverty Reduction Strategy Papers (PRSPs) (Cassels & Janowsky, 1998; Booth, 2003). At the same time, global development policy has become dominated by efforts to achieve the Millennium Development Goals (MDGs). Once again, however, there are few signs that older people are prominent in these new initiatives. The MDGs include several health-related goals, including reducing child and maternal mortality, and combating AIDS, malaria and other infectious diseases, but none refers specifically to older people. There has been increasing criticism about the development and implementation of PRSPs and SWAPs, and most have emphasised continuity of past policy priorities rather than fresh departures (Foster, 2000; Booth, 2003). Consequently, they do not facilitate the inclusion of specific programmes for older people.

Older people remain almost as marginal to global health policy debates as they were 50 years ago. Given global demographic and epidemiological trends, this is as remarkable as it is worrying. There is little indication that this almost wilful miasma will be rectified in the foreseeable future.

It is beyond the scope of this brief paper to give a detailed account of how specific aspects of health policy in developing countries relate to older people. One key issue is the need to 'mainstream' older people into discussion about health sector reform and the composition of selective health care packages and essential drug programmes. This includes considering the impacts which specific reform measures, such as decentralisation and cost recovery, may have on older people and their households. In many sub-Saharan countries severely affected by HIV/AIDS older people are playing an important role in caring for sick and surviving relatives. In many such countries, limited resources have led to a minimal package of basic health services from the state sector and NGOs, none of which address the health needs of older people. This undermines the capacity of older people to sustain their important contributions. In all countries, there is a need to assess the potential for primary health care to provide targeted interventions for older people, and to bridge the gap between formal health care provision and informal caring. Another key consideration is the need to identify those older people who are most vulnerable to ill health and its effects. The older population should not be treated as a homogeneous group, but as highly diverse, in terms of both their capacity to contribute to the health of others, and their own needs and vulnerabilities.

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Notes

- ¹ A survey of older people in rural Botswana found 21 per cent were moderately or severely malnourished. The survey pre-dated the onset of the AIDS epidemic (Clausen *et al*, 2000).
- ² This is the chapter ‘Health and nutrition services’ in World Bank (2004).

- ³ Sexual activity in later life is a very under-researched theme, but Knodel & Chayovan (2000) report that a high proportion of married Thais aged 50 or more remained sexually active.