

Essay for consideration of the 2008 Amulree Prize:**How will global ageing affect inequalities in health throughout the world?**

Population ageing is now a global phenomenon, worldwide the proportion of people alive over the age of 60 years is growing faster than any other age group (WHO 2002). It is expected that from 2000 until 2050 the world's population aged 60 and over will more than triple from 600 million to 2 billion (WHO 2006). Population ageing can be rightfully described as a "triumph of modern society" (WHO 2007a). It is attributed to improvements in medical technology, greater awareness of health issues and better healthcare services which have prevented premature death. However, whilst the older population undoubtedly have a great potential to contribute to society, the ageing population will put new economic and social demands on all countries. The elderly population increase will mainly occur in developing countries and by 2025 it is expected that 75% of older people will live in less developed areas of the world (WHO 2007a). The ageing population will have considerable implications for public health planning and inequalities in health relating to this phenomenon will have to be addressed.

In this essay, I will first provide a brief overview of definitions and trends relating to ageing. It is accepted that inequalities in health exist whether categorised by socioeconomic measures or by ethnic group or gender (Acheson 1998 and Leon and Walt 2001). I will consider how these inequalities in health are affected by the growing elderly population and what should be done to address them. I will argue that inequalities in health can also be categorised by age and that the negative cultural paradigm of old age has hampered elderly people's access to healthcare. In the body of my essay I will look at how international health policy (or lack thereof) has implications on the health of older people. Then I shall look at problems in healthcare provision at a national level for older people and how they will change with the growing elderly population. I will also consider what barriers to care the growing elderly population face compared to the rest of society. It is important to consider the inequalities in health that older people face in a global context because policy and action in the UK will influence and be influenced by international ageing policy and practices. In my conclusion I will emphasise how inequalities in health can be determined by age and have been created by society's views of older people. I also hope to suggest solutions for combating the inequalities in health elderly people face.

Definitions, inequalities and trends in ageing

Traditionally in the more economically developed nations, old age has been classed from the retirement at 65 years. However, this definition is not ideal and defining age purely in chronological terms does not account for cultural variations in age perception or changes in social roles (Lloyd-Sherlock 2000). As I will mention later, social and health determinants such as poverty and malnutrition can result in premature ageing before 65 years. Nonetheless from a statistical point of view, elderly people are usually classified as those who have obtained a minimum of 60 years, with most countries using data sets of 65 years and

over (Warnes 1998). Demographic aging is generally defined as an increase in the population aged 65 and over as a result of decreased fertility and increased longevity (Myers 1990). This is an established trend throughout the world except for Africa where in 2005 only 5 percent of its population were aged 60 or over (UN 2007a). It is predicted that in 2050 almost 80% of people over the age of 60 will live in developing countries (UN 2007a). Living to an older age does not necessarily mean longer periods of illness. In 2005, Fries put forward the widely accepted Compression of Morbidity hypothesis. This hypothesis proposes that older people are now spending a shorter time suffering from chronic illnesses, only in their very latter years of life. It is based on theory from the epidemiological transitional model which I will describe in detail later on.

Inequalities in average life expectancy are set to continue, women will carry on outliving men and in 2050 it is predicted that 61% of octogenarians will be women (UN 2007a). The fact that in Japan a woman is likely to live to 86 years, twice as long as a woman in Angola (life expectancy for women 41) is an inequality in itself (WHO 2007b). Most studies have found that women have a longer life expectancy than men, yet they spend a longer period of their life in ill health (Romero et al., 2005). This inequality in health will increase with global ageing and will have important implications for healthcare planning and resource allocation. However, it is difficult to go beyond the broad statements about differences in healthy life expectancy between men/women, developed/developing countries and to draw firm conclusions (UN 2007b). Therefore I will concentrate on examining the inequalities in health that older people face compared with younger people and are likely to increasingly face as the global society ages.

Lack of International Ageing Policy

Despite the evidence, international population ageing has not been viewed as a significant development issue until more recently. Inaction by policy makers has created inequalities in health and healthcare for older people in comparison with younger patients. The International Plan of Action on Ageing, created in 1982, was the first time that the world health forum concentrated on the health of older people (UN 1982). They had previously concentrated on maternal and child health needs. In 1991 the UN started to recognise the importance of dealing with the needs of the ageing population by creating the UN Principles for Older Persons. The 18 Principles fall under five main themes which are independence, participation, care, self-fulfilment and dignity. All of the Principles are valuable and relevant to tackling many of the inequalities in health older people face. Principle 11 in particular states that older people should have “access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.” Unfortunately whilst this document is a useful guideline for governments, the principles are not legally effective nor given as much priority as an international convention on the human rights of older people would be. Since there are conventions on human rights for other vulnerable groups such as women and children (OHCHR 1989, 1979), I find it difficult to understand why there is no similar convention for the elderly. It is equally disappointing that worldwide there is only one international NGO, HelpAge International which has a main interest in ageing, health and development (Lloyd-Sherlock 2002). NGOs carry out valuable work highlighting the plight of vulnerable people and help readdress inequalities in health. HelpAge International’s current campaign “Age Demands Action” (2008) hopes to raise awareness of needs of the elderly population on the

international development scene. Whilst HelpAge International is doing excellent work it is imperative that more NGOs develop to specifically champion Elderly people's rights and specific needs.

More recently, the 2002 Madrid Second World Assembly on Ageing highlighted the health and social issues elderly people face and produced the Madrid International Plan of Action on Ageing. This agreed plan tackles some of the policy and planning issues that the global ageing population will create and was adopted by governments worldwide. However, Kelly (2008) reports that implementation of the plan has been slow; especially in the area of mainstreaming aging into policy development. I believe that the lack of specific reference to elderly people in the Millennium Development Goals (UN 2005) helped to further isolate population ageing from the headlines. Unless ageing and its health related issues are better highlighted by governments, international bodies and the media, the likelihood of reducing the health inequalities associated with ageing is very small. This would have disastrous health implications for our growing elderly population.

Global Ageing - Implications for National Health Policy

Global ageing has brought about a change in the epidemiology of disease throughout the world. Omran first described the "epidemiological transitional model" in 1971 and proposed that corresponding to the demographic transition; there was a change in the burden of disease from communicable diseases to non communicable diseases. Since 1971 many different versions of the epidemiological transition model have been proposed but all have the same basis; that with improvements in living conditions and better healthcare, people can expect to live longer and suffer from fewer infectious diseases and more "lifestyle" related ones. In almost all regions of the world the burden of disease from non communicable diseases is rising (UN 2007b). Non communicable diseases such as hypertension, stroke, ischaemic heart disease, blindness and dementia are strongly associated with later life (Fried and Wallace 1992). Already Western unhealthy patterns of behaviour such as overeating and smoking have spread to the developing world (Boutayeb and Boutayeb 2005). This has caused corresponding increases in the prevalence of Diabetes and Lung Cancers especially in India and China. Elderly people from lower socio economic groups will be more likely to take up these habits and will be at greater risk of many non communicable chronic diseases (UN 2007b). The inequality in the burden of illness between different socio-economic groups will widen as the population ages.

Cataract problems which can cause blindness are disproportionately found to affect the elderly; 58% of cataracts worldwide were found to be in elderly patients, 88% of these in developing countries (Thylefors et al., 1995). With the ageing population levels of blindness will dramatically increase unless more health programs are created to treat this eminently curable problem. Without sight, elderly patients are more at risk of suffering from problems accessing healthcare services, poverty and social isolation, thus widening inequalities in health. The national healthcare provision of all countries must change to meet the needs of the elderly population and provide more treatment options for these non communicable diseases. Whilst in the UK, we can hope that the government and Department of Health will appropriately plan for these changes in healthcare provision e.g. the National Stroke Strategy published in 2007, it will be much harder for many less economically developed

countries. In particular, many African countries face a double burden of disease with elderly patients suffering from high levels of communicable diseases as well (Ghaffar et al., 2004).

Healthcare rationing is another area of contentious debate which will be exacerbated by the growing elderly population. In the UK and other developed nations the traditionally used theories of distributional justice (where the young are prioritised over the elderly) are based on utilitarian and egalitarian accounts of justice. In 2005 the National Institute for Health and Clinical Excellence in England and Wales stated that “where age is an indicator of benefit or risk, age discrimination is appropriate”. Firstly, I do not believe that the “fair innings” argument presented by Harris in 1985 on which the NICE guidelines are based is the most appropriate for the global ageing population today. Whilst the theory behind age-based resource allocation may stand true in the developed countries it is not applicable to all. Engleman and Johnson (2007) argue that in less economically developed countries the assumptions on which the theory of distributional justice are based do not apply as the elderly population are different in terms of chronological age, healthcare needs and contributions to society. They argue that elderly people are often undervalued and their rights are ignored. Engleman and Johnson recommend a Rights Based Approach for resource allocation, especially in developing countries. This approach considers the rights of all ages equally in resource allocation including the elderly. I believe that it is essential that countries try to adopt this approach if inequalities in health between the young and the old are to be tackled. Ageism is unacceptable and ethically the use of systems such as QALYS (quality adjusted life years) to ration healthcare as used in Oregon (Dixon and Welch 1991) will become more challenging.

National healthcare schemes in both developing countries and developed countries should create more health promotion campaigns for older people. With the ageing population it is likely that a greater number of people will be suffering from chronic/non communicable conditions such as hypertension which have recognised risk factors that can be controlled. In the past, older people have scarcely figured in national plans for essential primary health interventions (Lloyd-Sherlock, 2004). This must change because interventions such as stopping smoking and lowering blood pressure have very advantageous effects for the elderly population too but are often under encouraged (Lloyd-Jones 2004). Prevention campaigns for communicable diseases which affect the elderly are also needed. Allen et al., 2002 reported that older people are often excluded from HIV/AIDS campaigns ignoring the fact that they may be sexually active themselves and therefore at risk of infection. Elderly people are often the main carers for people living with HIV/AIDS (PLWA). A survey of older people caring for PLWA in Zimbabwe found that caregivers were under serious financial, physical and emotional stress due to their responsibilities (deGraft Agyarko et al., 2002). It was also reported that over half of the caregivers did not have access to support and faced stigma and social isolation because of their role. The unimaginably hard emotional burden of caring for someone with HIV/AIDS is not something which anyone should have to do alone. The role of the caregiver often falls to the elderly women in the family, a role which can be physically and emotionally demanding and can reduce the health of the women themselves (Allen et al., 2002). HelpAge International (2008) recently reported that it believed that the main reason elderly people are ignored in terms of HIV/AIDS prevention, policy and support was because there are no statistical indicators specifically for the over 50's age group in HIV/AIDS data. It has recommended that UNGASS indicators are expanded to include the over 50's; a recommendation which I hope is taken up.

To assist the ageing population increasing numbers of specialists in geriatric medicine and gerontology are needed. In Lebanon in 2001 there were only 7 registered geriatricians and considering that overall there are 325 physicians per 100,000 of the population, this figure is staggering (Abyad 2001). Similar trends are found throughout the developing and developed world. In Canada it has recently been reported that a lack of interest in elderly patients among medical students has helped create a shortage of geriatricians (Krivel 2008). It is important that students are properly trained in geriatric medicine because older patients tend to develop multiple co-morbidities and their problems are different from younger patients. Encouraging more students to take an interest in geriatric medicine and older people is essential to prevent a dearth of care for the growing elderly population. Fitzgerald et al., 2003 found that medical student's interest in geriatric medicine was greater where the students had cared for older people prior to their medical study. To encourage more students to take up the specialty of geriatric medicine they encourage influencing student's attitudes through their personal experiences in the care of the elderly. This was further emphasized by Lally and Crome in 2007 who recommended much greater emphasis should be given to the problems and care of older people in the Undergraduate training of all UK medical students. To further change, I believe more positive images of old age and the generalist and rewarding nature of caring for older people needs highlighting, especially through the media, educational facilities and government policy on a national and global scale.

Barriers to care

At a more personal level there are many barriers to accessing healthcare which elderly people face. The capacity of people to meet their basic needs is increasingly hindered by age (Allen et al., 2002). Many elderly people worldwide face extreme poverty, one Indonesian Woman described how "the good life is when I can find food" (HelpAge International 2001). Like other ages, the elderly from low socio-economic classes are prone to worse health (Townsend and Davidson 1982). In the UK, Life expectancy at age 65 years was 2.6 years greater in men from the first social class than class IV and V (Hattersly 1997). Long standing illness prevalence has been found to be 72% in older age unskilled manual groups compared with 53% in older age men from professional groups (Office for national statistics 1998). Recent research by Chandola et al., 2007 showed that social inequalities in self reported health increase in early old age, the elderly from lower social classes "age faster in terms of a quicker deterioration in physical health compared with people from higher grades". There is still debate about whether an individual's health is affected by their absolute income or the difference between their income and the average; their income inequality (Burholt and Windle 2006). Therefore any poverty reduction strategy must try to tackle poverty in old age and also tackle income inequalities in wealth amongst the elderly. In the UK, the social security and national pensions system does to some extent tackle inequalities in wealth in old age. Help the Aged in the UK and its worldwide arm HelpAge International used their Pensions not Poverty (2006) campaign to highlight the importance of social pensions and put pressure on governments to create pension schemes. 72 countries (46 of them middle or low income countries) now have social pensions schemes. However, most countries in Africa and many in the Far East still do not have this system, putting their elderly population in a very vulnerable position in terms of their health and wealth.

Deaton (2007) found in less economically developed countries there was a much stronger association between general decline in health satisfaction and rise in disability corresponding with increasing age. The Inverse Care Law (Hart 1971) can be applied to the elderly throughout the world; the elderly patients with the greatest need and from the lowest social economic background face barriers in accessing care (Allin et al., 2006). Poverty will have considerable implications on older individual's health, at a time when it is most needed. I believe that to diminish the health inequalities poverty creates, more emphasis by the UN and the WHO should be put on reducing old age poverty. The UN should create a progress indicator for Goal 1 of the Millennium Development Goals (UN 2005) specifically relating to reducing poverty in old age. This would highlight greater international attention to this area and would provide better means of tracking progress towards Goal 1 on the whole. The UK has led the way in recognising the disastrous affects of fuel poverty on elderly people's health. Other colder climate countries should be encouraged by the success of the 2001 UK's Fuel Poverty Strategy which has removed an estimated 4 million households out of fuel poverty since 1996.

The course of ageing exposes individuals to an amplified risk of illness and disability. In less developed countries the ageing process and life time exposure to illness and poverty means that some people enter old age already in chronic ill health. Access to health care services is imperative to these people yet in many cases it is inaccessible because the services tend to be located in urban areas, far from the majority of the elderly population living in rural parts of developing countries (Allen et al., 2002). Widening service to rural populations is a task many developing countries are trying to undertake. In India rural posting of medical students is currently being recommended by the Health Minister to tackle a shortage of doctors in villages. Yet this somewhat innovative approach is being opposed by students themselves (The Times of India 2007). Even within urban areas, elderly patients face difficulties in getting to hospital; in the UK lack of access to transport is experienced disproportionately amongst older people (Acheson 1998). The public transport systems in many developing countries are not adapted for older people or people with disabilities making it harder for elderly patients to access care. The WHO recognised these problems and how they will grow with the ageing population and with the parallel process of urbanisation, so in 2007 they created a guide to "Global Age-Friendly Cities" (WHO 2007c). This guide was created by working with older people in 33 cities worldwide to highlight the problems and advantages of living in cities. It is hoped that it will be used worldwide by governments, voluntary organisations and the private sector to improve aspects like transport for elderly people (WHO 2007c). Whether this guide will be used and to what extent it is successful is unclear at the present time but I believe that it could be used effectively to help address many of the problems brought on by social isolation that elderly people may face.

The affordability of healthcare and whether or not the state provides/does not provide free healthcare can become a barrier to health. In many developing countries private insurance is the main sector of health financing. The insurance companies often discriminate against the aged who are more likely to be suffering from expensive chronic conditions. For example in Chile most of the healthcare financing is through private insurance. Only 3% of the patients with private insurance are aged 60 or more compared with 12% of patients in the public hospitals/clinics (Stocker et al., 1999). The growing prominence of private health schemes throughout the world will further marginalise the aged from healthcare. In many countries, publicly funded healthcare services have some form of cost-recovery user fees. However, a

study in Ghana found that older people were unaware that they were exempt from paying user fees and this had decreased their utilisation (Ahenkora 1999). Lack of education and awareness about free healthcare provision due to communication problems (impaired hearing/sight) means that access to health in some countries is disproportionately harder for elderly people. Health financing must become more equitable between the ages on a global scale to help provide care for the ageing population.

Conclusion

I hope that I have demonstrated the importance of global changes in the way we view older people and how we provide healthcare services for them. On an international level, the health care needs of older people must be brought to the forefront of international attention and action. HelpAge International's "Age Demands Action" campaign will hopefully start to do this but governments other international bodies must follow with actions themselves. National Policy makers must consider the differing epidemiological patterns of disease that ageing brings and must ensure that healthcare provision addresses all of these needs. Ageist views in rationing of healthcare must change to accommodate the growing elderly population; it will not be and is not acceptable to discriminate against someone purely based on their age. A Rights Based approach to healthcare rationing, especially in less developed countries should be encouraged. It is important that health promotion campaigns are widened to include older people and more assistance and guidance must be provided to elderly people caring for PLWA. Medical training should put more emphasis on geriatric medicine and the exciting opportunities this field will encompass in the coming years as more and more older people survive into greater age.

It is imperative that greater efforts are made across the world to eradicate poverty in old age. I have demonstrated that poverty amongst the elderly creates even deeper inequalities in health than at any other age. Improving access to healthcare services for the elderly in rural and urban areas is another important concern. The WHO's "Global Age-Friendly Cities" is an excellent framework for change in this area, its goals must now be realised. Governments must carefully consider whether their healthcare provision and social services are affordable and accessible to older people; provisions must be made to ensure that they are.

The advances in medical technology, greater awareness of health issues and better healthcare provision have meant that for the first time in the world's history people have higher chances of surviving infancy and living to an old age. This ageing phenomenon is a triumph of society and now efforts must be made to ensure that older people are not viewed by their failing health but as valuable members of society. The healthcare services at an international, national and local level must respond to the needs of the ageing population to ensure that existing inequalities in health between socio-economic groups, gender, race and ethnicity are not widened. The elderly are a particularly vulnerable group and as Darkwa stated in 1997 "The mark of a noble society is not found in how it protects the powerful, but how it defends the vulnerable." It is imperative that efforts are made to combat ageism and protect the health rights of the growing elderly population. If this does not happen, inequalities in health worldwide will only widen, **now is the time to act.**

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