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# SOUTH AFRICAN DOCTORS AND ELDERLY PATIENTS

NTOBEKO NTUSI and MONICA FERREIRA

## Abstract

*This article reports on a country-wide postal survey of South African medical practitioners to determine their attitudes towards older people, Geriatric Medicine and older patients. A self-administered questionnaire was completed by 196 sampled respondents (a response rate of 21%). Scores on the Ageing Semantic Differential (Rosencranz & McNevin, 1969), a 7-point Likert-type scale, indicated judgement on 32 bipolar attribute dimensions, and were subjected to factor analysis and triangulated with the results of content analysis of qualitative data. Results showed that younger doctors ( $\leq 45$  years) with  $\leq 20$  years of medical practice who attend older patients daily/weekly and work in the private sector have less negative attitudes towards older people and older patients. Four-fifths of the sample was disinterested in a specialty in Geriatric Medicine. It is concluded that South African doctors' attitudes towards older patients are ageist and that an expanded Geriatric Medicine component in medical education curricula is indicated.*

## Introduction

The South African population aged 60 years and over is projected to increase from 6% of the total population in 2002 to 14% in 2050. In the same period the population aged 80 years and over is expected to more than double, from 8% to 19% of the total older population (UNPD, 2002). Longevity and an increase in the absolute number of persons in the very old age group in particular will result in a growing prevalence of age-associated chronic morbidity and disabling disorders, and thus an increasing demand for health care and burden on scarce health care resources. It is known that older persons are amongst the highest consumers of health care services.

The health care needs of older persons are however not viewed as a priority by South African health care planners, and scant resources are made available for the development and maintenance of facilities and services for geriatric care. Given an expanding older population, health professionals at all levels need to be prepared to meet the growing demand for health care for this population. To this end, for example,

aspects of ageing and a strong Geriatric Medicine component need to be more fully incorporated in medical education curricula.

Negative societal stereotypes and discriminatory ageist attitudes towards older people can influence both the quality of care that they are rendered (Gething, 1999) and the extent to which ageing is given attention in medical education curricula. It has been argued that ageism is endemic in an industry which places a high value on obtaining a "cure" and on working with "high tech" equipment (ibid.). Older patients are viewed as "bed blockers" who require longer hospital stays and as clinical failures because they cannot be cured (ibid.; Wilson, 1998). Health care professionals are not immune to common notions of older persons as frail, sick, dependent and vulnerable (Sainsbury, Wilkinson & Smith, 1992). Such stereotypes influence doctors' attitudes towards older patients and the nature of doctor-patient interaction.

Several authors have shown medical education to be a major source of negativity towards older patients, with students viewing the care of older





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patients as undesirable, unpleasant and unrewarding (ibid.). Studies of medical students' attitudes towards older patients have consistently found that training in Geriatric Medicine is not viewed by them as important or educationally beneficial (Le Couteur, Bansal & Price, 1996 and that students prefer not to work with older patients (WHO, 2001). Other studies have demonstrated the value of the incorporation of a geriatrics component in medical education programmes in developing more positive attitudes towards older people and older patients (Deary, Smith, Mitchell & McIennan, 1993), as well as towards Geriatric Medicine as a favourable specialty career option (Sainsbury *et al.*, 1992).

Debate in South Africa pertains to whether Geriatric Medicine is simply general medicine for older patients, or involves specific skills and expertise in disease and disorders common in older persons. Several local doctors reputedly do not see a need for a specialty in Geriatric Medicine, whereas protagonists for the specialty suggest that such views are held by health professionals who are disinclined to deal with multiple pathology, differential symptomatology and polypharmacy in older patients. While doctors generally see their mission as being to cure, heal and restore health, older patients who remain ill are possibly a threat to this defined role. A lack of tolerance of older patients may thus be prejudiced by attitudes which emanate from needs and defined roles as doctors (Silbert, 1981), as well as negative stereotypes and ageist attitudes whereby ageing is viewed as having an inevitable negative outcome.

No study had been conducted previously on the attitudes of South African medical doctors towards older people, Geriatric Medicine and older patients. The present study was informed by a recent similar survey conducted by the World Health Organization on Teaching Geriatrics in Medical Education (TeGeME2) (WHO, 2001) among 1,035 medical students in five African countries (Ghana, South Africa, Nigeria, Sudan, Tanzania). The WHO study found no differences in the attitudes of medical students in Africa compared to students in studies in North America. (Adelman, Fields & Jutagir, 1992; Reuben, Fullerton, Tschann *et al.*, 1995; Deary *et al.*, 1993; Sainsbury *et al.*, 1992). North American

(Wilkinson & Sainsbury, 1998; Deary *et al.*, 1993) and Australian (Gething, 1999) studies suggest though that contemporary medical students' attitudes are more positive than in the past. The WHO (2001) study found that having lived with grandparents for five years or more while growing up increased the likelihood of more positive attitudes and an intention to consider a specialty in Geriatric Medicine.

Against this background a survey was carried out among a sample of South African medical practitioners to determine their attitudes towards older people and older patients, and Geriatric Medicine as a specialty.

### Aims

The aims of the study were:

- To determine the attitudes of medical practitioners within the public and private sectors in South Africa towards older people in general and older patients, as well as Geriatric Medicine as a speciality.
- To identify determinants of the attitudes.
- To make recommendations to inform health care policy making and service planning, as well as medical education curricula development.

### Method

Data were collected through a country-wide postal survey of a sample of 1 000 medical practitioners drawn randomly without substitution from the registry of the South African Medical Association (SAMA). The sampling frame excluded paediatricians and obstetricians but represented all other doctors registered in the database.

A specially constructed survey questionnaire was pretested in a pilot study carried out among doctors at Groote Schuur Hospital, a tertiary care facility in Cape Town. The slightly revised questionnaire was thereafter mailed to the 1 000 sampled respondents for self-administration and anonymous return in an enclosed pre-paid envelope. The first mailing, in July 2002, resulted in a return of 148 completed

questionnaires and 58 unopened envelopes marked "address unknown." A second mailing, in September 2002, targeted 500 names randomly selected from the sample list after the names of the persons for whom unopened envelopes had been returned were removed; this mailing yielded an additional 48 completed questionnaires. A total of 196 doctors thus completed and returned questionnaires. After removal of the 58 cases who could not be reached from the sampling frame, the realised sample represented a survey response rate of 21%.

Completed questionnaires were coded, and the data captured and analysed using MS Excel 97. The analysis focused on a factor analysis of the respondents' scores on an attitude scale: the Ageing Semantic Differential (ASD), a Likert-type scale developed and validated by Rosencranz and McNevin (1969). Qualitative data from open-ended responses were content analysed and the results triangulated with the respondents' scores in the ASD.

Approval to conduct the survey was obtained from the Research Ethics Committee of the University of Cape Town's Health Sciences Faculty.

### Instrument

The instrument, or questionnaire used to collect the data was devised in three parts: The first part elicited personal data. The second part comprised the ASD, used in the WHO's TeGeME study (WHO, 2001), to measure attitudes towards older people. The ASD consists of 32 items of bipolar adjectives which describe behavioural characteristics or attributes of persons of all ages. The survey respondents were required to make personal judgements about older people in general on a 7-point scale for each pair of opposite attributes. Each item score is a separate and independent judgement. The third part of the questionnaire required responses to open-ended items on professional, personal and other factors as determinants of attitudes towards older patients.

### Sample

Table 1 summarises the characteristics of the realised survey sample (N=196). The respondents were predominately male (70.9%). The mean age of the

**Table 1: Sample profile**

| Characteristics   | %(N=196)  |
|---|-----------|
| <b>Total</b>  | 100.0     |
| <b>Gender</b>   |           |
| Male  | 70.9      |
| Female  | 29.1      |
| <b>Age group (years)</b>                                |           |
| 25 - 39   | 35.2      |
| 40 - 59   | 53.0      |
| >60   | 11.7      |
| Mean  | 45.4      |
| Range   | (25 - 84) |
| <b>Duration practised medicine (years)</b>              |           |
| 1 - 19  | 50.0      |
| 20 - 39   | 42.4      |
| 40 - 59   | 7.1       |
| Mean  | 19.7      |
| Range   | (1 - 59)  |
| <b>Employment sector</b>                                |           |
| Private only  | 52.6      |
| Public only   | 21.9      |
| Private and public                                      | 23.9      |
| NGO   | 1.3       |
| <b>Public sector level (N=98)</b>                       |           |
| Primary   | 25.5      |
| Secondary   | 24.5      |
| Tertiary  | 33.7      |
| Multiple levels   | 8.2       |
| Unspecified   | 8.2       |
| <b>Frequency attends older patients</b>                 |           |
| Daily   | 78.5      |
| Once a week or more                                     | 10.7      |
| Less than once a week                                   | 7.6       |
| Never   | 3.1       |
| <b>Speciality</b>                                       |           |
| No (general practitioner)                               | 53.6      |
| Yes   | 46.4      |
| <b>Postgraduate course in Geriatric Medicine</b>        |           |
| Yes   | 3.1       |
| <b>Ever considered speciality in Geriatric Medicine</b> |           |
| Yes   | 6.6       |
| No  | 80.6      |
| Might consider in future                                | 12.8      |

sample was 45.4 years (range 25 - 84). Slightly more than half the respondents (53.6%) were general practitioners and the remainder were specialists. The mean number of years that the respondents had practised medicine was 19.7 (range 1 - 59). Slightly more than half (52.6%) worked in the private sector, 21.9% in the public sector, 23.9% in both sectors, and 1.3% were employed by NGOs. The 98 respondents who worked full time or part time in the public sector were fairly evenly spread over tertiary (33), secondary (24) and primary (25) levels; 8 worked at multiple levels (missing values = 8).

Only four respondents attended older patients exclusively; 87.2% attended such patients daily or weekly, 7.6% did so less often and 3.4% never attended older patients. Only 3.1% of the sample had post-graduate training in Geriatric Medicine. Minorities had considered a specialty in this area (6.6%), or might do so in the future (12.8%); four-fifths had never and would not consider a specialty in Geriatric Medicine.

## Results

The results of an analysis of the data from the Ageing Semantic Differential using chi square are shown first, followed by results of an analysis of the qualitative responses to open-ended items.

The ASD were analysed by aggregating the scores on the 32 bipolar attribute dimensions. The dimensions, or factors are arranged in three groups, which constitute the original ASD authors' factor structure: Instrumental - Ineffective (I - I); Autonomous - Dependent (A- D); and Personal Acceptability-Unacceptability (AU). Instrumentality is taken to reflect adaptability, vitality or activity level; autonomy the extent to which a person is self-sufficient, and is a contributor to, rather than a recipient of the system; and personal acceptability as the extent to which a person is regarded as socially pleasing to others (Wilkinson & Sainsbury, 1998). Following the original authors' factor structure, bipolar attribute dimensions are grouped according to sequential numbers of the dimensions as follows: I - I: 1 - 9; A- D: 10 -18; and A -U: 19-32.

The median scores of responses on each bipolar

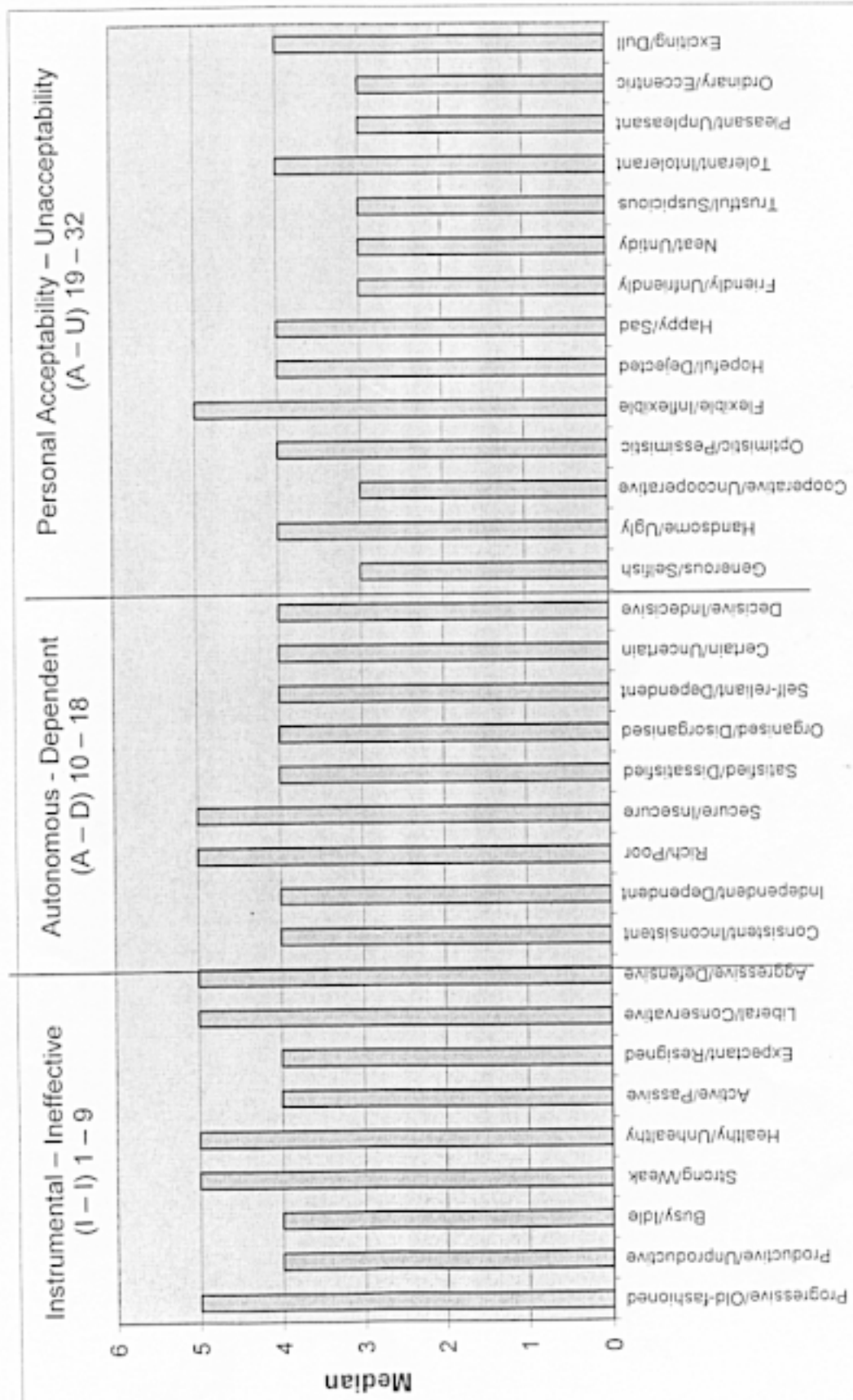
attribute dimension and the groups of dimensions are shown graphically in Figure 1. A higher score value indicates a more negative attitude towards the target object, i.e. older people. For the majority of the dimensions the scores are negative (they fall above the median). No dimensions have scores which indicate a positive attitude towards those attributes, but seven have scores which indicate neutral attitudes towards specific attributes: specifically, older persons are not necessarily viewed as selfish, uncooperative, unfriendly, untidy, suspicious, unpleasant or eccentric.

Respondent ratings for bipolar attribute dimensions are found to cluster within the three groups of dimensions in a similar way to that found by the ASD authors. Median scores for attitudes within groups of attribute dimensions in the present study were I I = 5; A- D = 4; and A - U = 3. Progressively less negative attitudes towards attributes are noted from left to right across the dimensions and the groups, which indicate least negative attitudes towards personal acceptability factors and most negative attitudes towards instrumentality factors. Hence, while this sample of doctors viewed older persons as relatively "personally acceptable," they viewed older persons' autonomy as compromised and their instrumentality, or ability to function independently as particularly compromised.

The ASD cluster group rating scores were correlated with various respondent sociodemographic variables: age; gender; duration practised as a doctor; frequency attends older patients; health care sector in which works; and level within the public sector, if applicable. No differences were found in the respondents' attitudes towards older persons' instrumentality (I - I) and autonomy (A - U) in this case, but statistically significant differences were found for a number of the variables in the acceptability (A - U) factors group.

The differences are shown as p values and were found for age (younger respondents (< 45 years) were less negative towards older persons ( $p < 0.001$ )); duration practised as a doctor (attitudes were less negative where respondents had worked < 20 years ( $p < 0.001$ )); frequency attends older patients (less negative attitudes where respondents attend

**Figure 1: Median scores of responses to bipolar attribute dimensions in the Ageing Semantic Differential**



older patients daily or weekly ( $p < 0.001$ ); and work sector (less negative attitudes where respondents work in the private sector ( $p < 0.001$ )). No statistically significant differences were found for gender or public sector level worked. In sum, younger doctors who have practised medicine for a shorter duration, who work in the private sector and who attend older patients frequently, were found to be less negative towards older persons than older doctors with a longer duration of medical practice, who work in the public sector and who attend older patients infrequently.

Results of an analysis of the responses to the open-ended items are as follows: Of the four-fifths of the respondents who reported that they had never considered a specialty in Geriatric Medicine and would neither do so in the future, approximately 40% explained that they were "disinterested," "disliked older people," "would like a more cosmetic practice," "would hate Geriatric Medicine," or similar. The remainder explained that they had either chosen a different specialty, or wanted to remain in general practice, while several added that they attend numerous older patients in their practice anyway.

Asked to describe older persons, 54% described them positively (as "wise" "thoughtful," "valuable," "instructive," "friendly~" "pleasant," "tolerant," "self reliant," etc.); 10% described them neutrally but acceptingly ("ordinary people" "human beings "same as young people"); another tenth qualified their responses ("hopeful, pleasant but time consuming;" "unique but difficult;" "people who lived a full life but now want to die"); while the remainder described older persons negatively ("poorly off economically which influences their negative attitudes;" "generally in poor health with no future from a physical and mental point of view;" "depressed, unfulfilled, lonely, dependent;" "frail, stuck in the way they think;" "unutilized, lonely, difficult to change;" "more prone to sickness and side effects of treatments;" "frail and needing to be taken care of").

A fifth of the respondents reported negative feelings towards older patients and described them variously as "difficult, tiresome," "time-consuming," "slow

and stubborn," and "having numerous minor complaints". The majority reported positive feelings, indicating that they found working with such patients enjoyable, rewarding, pleasant, instructive and challenging ("they make me happy;" "they are good to work with;" "glad to be of help;" "a privilege"). Some respondents qualified their responses, pointing out that while work with older patients may be satisfying, it is frustrating where patients have financial constraints - or expect a free service, and where patients are confused, incontinent and/or very infirm. A few responded positively but stated they would not want to work exclusively with older patients.

Regarding how working with older patients differs from working with younger patients, 15% viewed work with older patients positively ("more satisfying," "less demanding," "more appreciative," "less arrogant" - than work with other age groups), but three quarters viewed such work negatively ("more time consuming," "more difficult," "suspicious," "inflexible," "higher risk," "more physical illness"). Minorities viewed work with older patients as no different to that with patients in other age groups, or mentioned that only the specific needs of older patients such as the spectrum of illness in the older population are different.

Finally, the respondents indicated factors such as religion and culture, and systems related, institutional and personal factors which influence the way they feel about, interact with and render care to older patients. The majority cited cultural, religious and personal factors: Personal factors, where the respondent "[has] always enjoyed working with older people;" "[has] a grandmother [or an elderly mother], so has a soft spot for older patients;" "has experience of older people in the family circle." Religious and cultural factors, where "my cultural and religious principles determine how I treat all patients regardless of age;" "my upbringing;" "I was brought up to respect older people." Several respondents pointed to economic, institutional and systems related constraints which affect the care they are able to render older patients: "Most older patients need more expensive treatments for which the government service does not work well;" "the



government system is too slow, not enough medicine or trained personnel in clinics;" "insufficient medical aid coverage;" "additional costs for older patients;" "limited financial resources, care facilities;" "[they - older patients] need separate care facilities;" "[they] are concerned that private facilities and fees are too costly;" "working in the public service.... adequate care facilities are not provided for older patients, e.g. wheelchairs, transport assistance;" "financial [in]ability of patients;" "the long queues cause patient discomfort;" "many doctors do not listen to their problems;" "health-system related factors are the major obstacle to rendering quality care;" "most of my patients do not have sufficient funds to pay for certain tests." Professional and patient related factors which affected the nature of the care or quality care that several respondents perceived they are able to render included: "Inability to communicate with a senile patient;" "in private practice I can take time and accommodate [older patients'] slowness or deafness, state institutions don't afford doctors this time;" "you need to provide enough time for yourself to treat them with quality care;" "you need knowledge of the background of the patient and his/her relationship to immediate surroundings;" "I try to give good quality service and time to older people."

### Discussion and conclusions

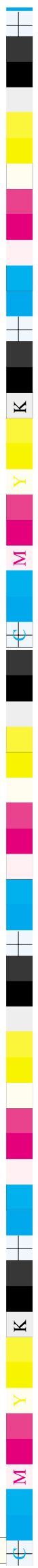
The results show that younger doctors who have practised medicine for a shorter duration, who work in the private sector and who attend older patients frequently ( $p < 0.001$ ) are least negative in their attitudes towards older people and older patients. The findings are borne out by the results of a content analysis of the qualitative data. Triangulation of the results of the analyses of both the ASD scores and the qualitative data shows that whereas the sample of medical practitioners were least negative towards older persons in terms of personal acceptability factors, in general they viewed older persons as dependent, based on infirmity and vulnerability factors, which they viewed as comprising older persons' autonomy. In particular, older persons were viewed as ineffective, based on perceived negative behavioural attributes, rather than instrumental in their daily lives. The respondents' attitudes towards

older persons and older patients were therefore negative overall, although somewhat mitigated where personal attributes of such persons were more acceptable than other attributes.

Past research on the attitudes of both medical practitioners and medical students towards older persons, primarily in Western countries, has consistently found high rates of attitudinal negativity. The negativity may be a function of a focus on decrements associated with ageing, which reinforces negative stereotypes. However, recent studies suggest that medical students' attitudes are more positive, or correctly speaking less negative than in the past, which may be due to a number of developments. The present study similarly found that younger doctors with a shorter duration of medical practice - and thus whose medical training was more recent - were least negative in their attitudes.

The recognition of Geriatric Medicine as a specialty has been fairly recent. The subdiscipline has subsequently been incorporated in medical education curricula to a greater extent. In addition, community medicine has played a greater role in the training of doctors, who are now afforded an opportunity to work with comparatively healthy older patients in the community, and not only with frail and sick older patients in the wards of training institutions. On the other hand greater exposure of trainee doctors to comparatively healthier older patients does not appear to have influenced their career choices to specialise in Geriatric Medicine, as was borne out in the disinterest in this specialty area expressed by four-fifths of the study sample.

Doctors who work in the private sector in South Africa were found to be less negative in their attitudes compared to their counterparts in the public sector. An explanation for this finding may be that private doctors see fewer patients and have more time to spend with older patients, and are able to build a more rewarding doctor-patient relationship over a longer period. Private doctors' patients neither face the same financial constraints as public health care patients do, and being more educated usually, are more knowledgeable about their health conditions. However, some private patients' inability



or unwillingness to pay for services was found to be a contributing factor to some doctors' negativity towards older patients. Several doctors indicated that they do not view Geriatric Medicine as a sufficiently lucrative specialty.

Overall, frequent attendance to older patients, or relatively high levels of contact with older patients was found to be the strongest determinant of less negative attitudes towards these patients, with doctors who attend them daily being most positive in their attitudes. Doctors' greater exposure to older patients may thus engender more realistic expectations of and reasonable attitudes towards older patients, and thereby mitigate negative perceptions or stereotypes. However, a selection bias may be at play where doctors who enjoy working with older patients attend them more frequently, and vice versa.

Descriptions of older persons in the qualitative data reflect more positive attitudes in general than do the ASD scores, although the spontaneous descriptions remain ageist. Ageism refers to generalised negative stereotypes and consequent discrimination against older persons on grounds of their age. Several respondents viewed work with older patients as less desirable because of commonly perceived negative therapeutic outcomes, as well as consultations being more time consuming and such patients being more difficult to work with. In all cases the respondents cited stereotypical attributes of older persons to support their views.

Factors identified in the qualitative data which influence doctors' attitudes were religion, culture, economics, system and institution related. Although the respondents ethnicity was not recorded, spontaneous responses were indicative of strong religious and cultural norms of respect held towards elders, presumably largely by African and Muslim respondents. Financial constraints were cited by respondents in both the private and public sectors, with doctors in the public sector referring to inadequate financial resources, or sub-optimal government resource allocation which translates into poor quality health care. Both institutional and systemic factors were cited as impacting the nature of interactions between doctors and patients, and therefore compromising the quality of care that doctors are able to provide.

The study findings highlight a need for expanded training in Geriatric Medicine at undergraduate and postgraduate levels, and for a greater allocation of resources for geriatric care - certainly in South Africa but probably in most developing countries. The elimination of ageist attitudes must be a task for all medical education institutions.

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# OLDER PERSONS OF GHANA

CHUKS J. MBA

## Introduction

The demographic trends of past decades in Africa and other developing regions are leading to unprecedented increases not only in the absolute numbers of older persons but also in the relative share of the population that belong to the elderly age groups. The increase in the proportion of the elderly is no longer limited to the industrialized countries since the population of the rest of the developing countries is also now aging at unprecedented rates. In Africa, despite the fact that the population of people aged 60 years and older constituted only 5.1 percent of the total population by the year 2000, this percentage translates to a very large number of people. Specifically, the United Nations (1999) medium-variant projection estimates show that 38.9 million Africans are aged 60 years and over (with females accounting for 21.3 million of the total) by the year 2000. It is expected that by 2025, this figure will rise to 80.3 million (with females outnumbering to the tune of 43.2 million). The recent decline in fertility observed in various developing regions including Africa, coupled with changes in mortality trends following the steady decline of the early twentieth century are accelerating the population aging process. The numerical growth of elderly persons around the world is an eloquent testimony not only of reductions in fertility but also of reductions in infant and maternal mortality, improved nutrition, reduction in infectious and parasitic diseases, as well as improvement in health care, education and income. Global total fertility rate has declined from 5.0 live births per woman in 1950-1955 to 2.7 live births per woman in 2000-2005, and is expected to further reduce to replacement level, that is 2.2 live births per woman by 2045-2050 period (United Nations, 2001). Also life expectancy has increased from 46.5 years in 1950-1955 to 66.0 years in 2000-2005, and is expected to rise to 76 years by the 2045-2050. In sub-Saharan Africa, the corresponding fertility

values are 6.7 live births per woman in the early 1950s to 5.5 live births per woman by early 2000s and 2.4 live births per woman by 2045-2050 period. Similarly, expectation of life at birth rose from 36.7 years in the 1950s to 48.4 years by 2000-2005, and is projected to peak at 68.4 years during the 2045-2050 period.

Ghana's fertility and mortality profile is similar to that of sub-Saharan Africa. This is because fertility fell from 6.9 to 4.2 live births per woman in one half century, and is expected to fall to replacement level during 2045-2050 period, while life expectancy increased from 42.0 to 57.2 years in five decades, and is expected to reach 71.1 years by 2045-2050 period (United Nations, 2001).

## Geography

Ghana is located in the West African sub-region, with a land area of 239,460 square kilometres (consisting of land: 230,940 sq km, and water: 8,520 sq km). It borders the Gulf of Guinea, between Cote d'Ivoire and Togo. Ghana's topography indicates that it is a low-lying country, in general, with dissected plateau in south-central area. The only stretch of hills lies on the eastern border with Togo and the west of the Volta River (the Lake Volta is the world's largest artificial lake). Along the coast is the Savannah grassland that is criss-crossed by several rivers and streams that are navigable by canoe. In the west and central parts of the country is heavily forested terrain, while in the northern part lies an undulating Savannah. The climatic condition of Ghana is tropical with average annual temperature of about 26° Celsius (79° Fahrenheit). The climate is therefore warm, and comparatively dry along southeast coast; hot and humid in southwest; hot and dry in north. There are two rainy seasons in the southern part of the country; between April and July, and between September and October. But only one rainy season characterises the northern part of the



country - occurring between March and September.

### History

Ghana, formerly Gold Coast, gained political independence from Britain on 6th March 1957, the first country in colonial Africa to gain its independence. A long series of coups resulted in the suspension of the constitution in 1981 and the banning of political parties. A new constitution, restoring multiparty politics, was approved in 1992. Flt. Lt. Jerry I, Rawlings, head of state since 1981, won presidential elections in 1992 and 1996, but was constitutionally prevented from running for a third term in 2000. He was succeeded by John Kufour. The country operates a parliamentary system of government (unicameral Parliament of 200 seats; members are elected by direct, popular vote to serve four-year terms). Ghana has a three-tier local government. At the first level are the 10 administrative regions (Ashanti, Brong-Ahafo, Central, Eastern, Greater Accra, Northern, Upper East, Upper West, Volta, Western) into which the country is divided; followed by the 110 districts, which are subdivisions of the regions; and then the unit committees. The capital city is Accra.

### Economy

Agriculture (agricultural products include cocoa, rice, coffee, cassava (tapioca), peanuts, corn, Shea nuts, bananas; timber) is the main economic activity, and currently accounts for about 51 percent of the Gross Domestic Product (GDP), and employs about 60 percent of the labour force. Tourism is fast becoming a significant foreign exchange earner. The natural resources include gold, timber, industrial diamonds, bauxite, manganese, fish, rubber, hydropower.

Well endowed with natural resources, Ghana has roughly twice the per capita output of the poorer countries in West Africa. Even so, Ghana remains heavily dependent on international financial and technical assistance. Gold, timber, and cocoa production are major sources of foreign exchange. The domestic economy continues to revolve around subsistence agriculture, which accounts for 36% of

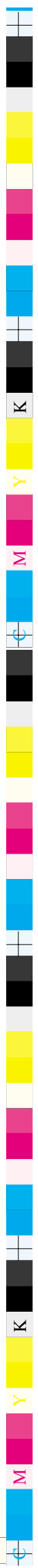
GDP and employs 60% of the work force, mainly small landholders. Excessively expansionary monetary and fiscal policy prior to the 2000 elections led to accelerating inflation in early 2001. A depressed cocoa market and continued weak growth in non-traditional exports led to disappointing growth in 2001. Ghana opted for debt relief under the Heavily Indebted Poor Country (HIPC) programme 2002.

### Demography

The 2000 Population and Housing Census of Ghana yielded a population headcount of 18.9 million, up by 53.8 percent over the 1984 population of 12.3 million, representing an intercensal growth rate of 2.7 percent per annum (Ghana Statistical Service, 2002). Ghana has still a youthful population as the proportion of the population under 15 years of age, 41.3 percent of the total population, is higher than the other population subgroups, although this represents a decline from the 1984 proportion of 45.0 percent. However, it is remarkable that the proportion of the elderly population (persons aged 65 and over) increased from 4.0 percent in 1984 to 5.3 percent in 2000. The ratio of the elderly to the children also increased from 8.5 percent in 1984 to 12.8 in 2000, while the median age rose from 18.1 years to 19.4 years over the same period. All this is an indication of an ageing society, as well as a reflection of declining fertility and also of rising life expectancy resulting from improvements in public health, sanitation, and nutrition. Furthermore, as is the case in most populations, the ageing phenomenon is more pronounced among females than males in Ghana. Elderly persons aged 60 years and over, and 65 years and over are expected to constitute 14.7 percent and 10.1 percent respectively of the total population by 2050, while the median age is expected to rise to 33.1 years over the same period (United Nations, 2001).

### Societal Implications on Ageing: The Family

Traditionally, the Ghanaian family can be described as an extended family of three or more generations descended in a direct line of female members (matrilineal - the Akan ethnic groups) or male



members (patrilineal - northern ethnic groups and the Ewes and Gas of the southern coast). The extended family often includes man, wife, children, parents, grandparents, brothers, sisters, cousins, and in-laws. The members of the extended family are obliged to assist each other in times of crisis and to share the achievements and glory that individual members bring. In this way, the young, old, and infirm members of the family are taken care of as the need arises.

An important characteristic of the traditional Ghanaian family system is the subordination of the younger members to the older members of the family (Apt, 1992). Within the family structure, there are norms and patterns of behaviour between the old and the young. For instance, it is expected that one shows respect to one's elders and is friendly and courteous to one's peers and juniors. Within the family domestic group (household), members are expected to share relationships based on respect, courtesy, and assistance to one another. This social arrangement enables the young and old to engage in productive ventures and share intergenerational experiences - the young have something to learn from the old, and the old are given a helping hand.

Under the traditional Ghanaian system, the elderly persons occupy important places in the family system and are respected. The young in matters of important decision-making consult them, and this interaction gives them a sense of self-worth.

This age-long situation has been changing in recent times due to changing socio-economic environment, and the nuclear family appears to be assuming a significant part of providing care and assistance for the elderly persons (Mba, 2002a; Mbamaonyekwu, 2001; Apt, 1992; Apt, 1991; Apt van Ham, 1989; Brown, 1985).

### **Societal Implications on Ageing: Care/Services for Older Persons in Ghana**

Not all elderly persons have access to health services, especially in the rural areas. It is recognized that the government of Ghana is planning a new National Health Insurance Scheme (NHIS) under which

adequate provisions will be made to exempt the aged (*Daily Graphic*, 2003). Currently, however, the cash-and-carry system (a user-fee scheme that entails full cost recovery for medical attention) affects all population subgroups. As a result of the economic situation in the country and its concomitant low standard of living and poor quality of life, the average elderly person finds it increasingly difficult to pay hospital bills.

The government of Ghana has introduced a pension scheme to cover all Ghanaians in the workforce, including the self-employed. The government is also promoting the provision of day centres for the aged by the private sector, including non-governmental organisations (such as HelpAge Ghana), to provide companionship and supplementary feeding, as well as regular health checks for older persons in Accra and other places.

The government is also seeking to promote the provision of specialised health care (geriatric medicine) for the elderly persons in state and private hospital and clinics. Additionally, Ghana's government seeks to encourage all workers, including the self-employed to contribute to a social security pension scheme, and to ensure that a pension paid to a retired employee is continuously indexed. While acknowledging the importance of these laudable initiatives, their actual implementation that will translate into improvement in the standard of living of the elderly persons is yet to be seen.

Presently in Ghana, due to the lack of a comprehensive social security system for all, the family continues to be the dominant source of care for the older population. However, the extended family system is steadily breaking down as a result of modernization and urbanization (Mba, 2002a; Mba, 2002b; Mbamaonyekwu, 2001; McDonald, 1992; Martin, 1990; Goode, 1963). As the extended family declines under the pressure of the changing social and economic environment, responsibility for the care of the elderly is rapidly being transferred to the nuclear family, which in Ghana and other developing countries, however, is not well equipped to address the issue. As a result of lack of full knowledge of the implications of the changes taking



place in the traditional family, it is still assumed in most of the African settings that the family will continue to provide the context within which the needs of the older population could be met.

### Economic Implications

It goes without saying that the ageing process exposes individuals to increasing risk of illness and disability. As Ghana is a poor country, lifetime exposure to health problems means that many Ghanaians may enter old age already in chronic ill-health. Consequently, personal health consistently ranks alongside material security as a priority concern. Physical health is for many elderly persons, especially those residing in the rural areas, their single most important asset, bound up with their ability to work in the farms, to function independently and to maintain a reasonable standard of living. Illness in old age is therefore an ever-present threat.

Despite its importance to the elderly people, healthcare is inaccessible to many Ghanaians, including the aged. Hospitals are more or less concentrated in the urban centres, far from the rural areas where the majority of Ghanaians still live. Even those elderly people who live in cities and towns can often only reach health facilities by using public transport (trotro), which is expensive and not adapted for easy access.

It should be noted that women generally live longer than men and are therefore more likely to be widowed. Widows often lose their property, including their home, due to patriarchal inheritance rules in some sections of the country. These women also tend to experience reduced social status on losing a husband. Thus, older women are more likely to be economically dependent on their families than men, having had less access to income-generating opportunities and assets, and lower wages.

Older men, on the other hand, may find themselves rejected by family and community once they are unable to earn an income, as they are seen as unproductive and their caregiving or other support roles may not be recognised. The importance attached to the traditional male role of economic provider is such that great loss of status and respect

may be associated with retirement from productive work due to ageing or poor health.

### Recommendations

It should be noted that welfare policies affect only the few engaged in formal employment. Unfortunately, welfare policies in Ghana and many developing countries are modelled along the lines of the Western family structure and, thus, do not promote the traditional kinship unit. For instance, medical policies directly and indirectly discriminate against the preservation of the extended family system by allowing for the inclusion of only one spouse, even where the family is polygynous.

The government has set aside c24bn (or about US \$2.8m) under the current health exemption policy in which the elderly persons aged 70 years and above, as well as children under age 5 and pregnant women will benefit from free medical attention at public hospitals and clinics (Mingle, 2003). The scheme is expected to go a long way toward defraying the medical bills of the sick. However, efforts should be made to attain this objective at the shortest possible time to alleviate the sufferings of the aged. Moreover, the cut-off point for qualification under this scheme for the aged should be reviewed to cover the elderly persons aged 60 years and over since that is the official retirement age in the country.

**From the preceding profile several critical issues relating to population aging research in Africa have emerged. Research which will inform policy and planning for an aging population is a priority area in the region. Training of researchers will be important in terms of strengthening the region's capacity to monitor trends, as well as to conduct research and explore new directions in population aging research. Also subregional networks that could facilitate exchange of information, resource sharing, training opportunities, and more importantly, effective dissemination of research findings are increasingly needful. Such networks may be developed by the relevant international agencies in conjunction with appropriate persons at the national level to ensure optimal co-operation and success of research endeavours.**



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# DISEASE AND DISABILITY BURDEN OF ELDERLY WOMEN IN INDIA

R. S. GOYAL

## INTRODUCTION

From the beginning of the 20th Century, almost all nations of the world have noted an increase in the life expectancy of their people. This transition in the health scenario has occurred at different rates in different countries. The developed regions have added more years to the lives of their people than the developing ones. Further, these changes have not been uniform for all people. For example, the female life expectancy has been rising continuously, while the gains in the case of males have slowed significantly, and in some cases have even leveled off. The gender differentials in the pace of change in life expectancy we also affected differentially, in different regions. In several countries (mostly in the developed world), where male and female life expectancies were similar, females have acquired an edge. In countries where females had a lower life expectancy than men (largely in developing countries), gender gaps have narrowed. Demographers have anticipated that with the continuation of the current trend in developing countries the gender gap will widen again, but with an advantage to women.

As individuals live longer, the quality of that longer life becomes a crucial issue. Are the additional years gained healthy and productive years, or are these spent with disability, ill-health, misery and mental disorder? Against the backdrop of a higher longevity, this issue becomes particularly relevant for women. It is noted that in many developing countries, women generally have unequal and inadequate access to basic services, food and nutrition throughout their lives. In several poor households and communities women work harder than men, but eat less. These factors along with neglect and discrimination during child-bearing years lead to chronic health problems for them in old age. Under these circumstances, it is

believed that women may live additional years in ill-health (UNFPA; 1998). This assumption is based on the behaviour of particular biological factors that lead to a higher disease and disability burden among women in old age and, which are further exacerbated by life-long discriminating treatment against them. For example, women may have adverse physical effects of changing hormonal levels after cessation of menses. These include increased risk of heart disease, osteoporosis, and an acceleration of the changes in skin, muscles and other tissues associated with aging. The risk of reproductive tract infections increases due to the drying and thinning of vaginal walls. Psychological changes include a loss of sexual appetite and pleasure, mood and depression. These are also influenced by changing social identities and self-perception. For the past few decades, research has been moving towards the development of health indices that take into account not only mortality but also various parameters of health. Though in real terms, healthy life expectancy is not necessarily expectancy free of diseases, such as hypertension, the concept of healthy life expectancy as normally used, refers to expectancy without limitation of function that may be the consequence of one or more chronic disease conditions (Kinsella et. 1993). However, these assumptions require detailed or longitudinal data that are currently not available for many developing countries including India.

## DATA

This paper attempts a comparative analysis of disease and disability burden of elderly men and women in India on the basis of data drawn from several large scale surveys and censuses.

It is a macro analysis based on data drawn from National Family Health Survey (NFHS): 1992-93, National Sample Survey (NSS) of 1986-87 (42nd

round) and 1995-96 (52nd round), Sample Registration Scheme (SRS) and Indian Censuses etc. Further, elderly or aged persons have been defined as those who have completed 60 years or more of life. This definition of the aged could be debated because, in many developed countries, persons aged 65 or above are defined as aged. The above age limit is decided on the basis of prevailing norms in India. It in turn is determined by the retirement age applicable in the formal or organized sector. Further, in most surveys in India, persons of 60 years and above are considered as elderly.

The data sources mentioned above provide large cross-sectional community based data. The 42nd and 52nd rounds of NSS have specifically collected information on the socio-economic and health status of the elderly by surveying one percent of all households in India. Though the NFHS focused on collecting information on reproductive and child health care from nearly 100,000 households across the country, it has also generated valuable information on the disease and disability burden of the elderly in these households. In the present analysis, the focus is on comparing aspects of

physical well-being of the elderly. The variables used include

- (a) Nature of physical disability (disability burden)
  1. Visual
  2. Hearing
  3. Locomotion
  4. Amnesia
  5. Speech
  6. Any disability
- (b) Type of diseases (chronic diseases)
  1. High Blood pressure
  2. Problem / pain in joints
  3. Cough
  4. Heart disease
  5. Other diseases

## ANALYSIS

### I. Growth Pattern

As per the 1991 census of India, there were 57.19 million people in the elderly age group of 60+ years. In proportionate terms, this accounts for 6.8 per cent of India's total population (Table 1).

**Table 1: Number and Proportion of Aged (60+) in India: 1961-1991 (Numbers in million)**

| Sex           | Census Year |       |       |       |
|---------------|-------------|-------|-------|-------|
|               | 1961        | 1971  | 1981  | 1991  |
| <b>Male</b>   |             |       |       |       |
| i. Number     | 12.36       | 16.87 | 22.02 | 29.63 |
| ii. Percent   | 5.6         | 5.9   | 6.2   | 6.7   |
| <b>Female</b> |             |       |       |       |
| i. Number     | 12.35       | 15.83 | 21.14 | 27.56 |
| ii. Percent   | 5.9         | 6.0   | 16.4  | 6.8   |
| <b>Total</b>  |             |       |       |       |
| i. Number     | 24.71       | 32.7  | 43.16 | 57.19 |
| ii. Percent   | 5.6         | 6.0   | 6.3   | 6.8   |

Sources: Registrar General and Census Commissioner of India, State Profile, 1991, India.

**Table 2: Projected figures of aged (60+) Population in India: 1996-2016 (In millions)**

| Year                          | Males           | Females         | Persons          |
|-------------------------------|-----------------|-----------------|------------------|
| <b>1996</b><br>No.<br>Percent | 32.32<br>(6.67) | 29.99<br>(6.67) | 62.32<br>(6.67)  |
| <b>2001</b><br>No.<br>Percent | 36.21<br>(6.91) | 34.36<br>(7.03) | 70.57<br>(6.97)  |
| <b>2006</b><br>No.<br>Percent | 41.83<br>(7.41) | 39.99<br>(7.55) | 81.81<br>(7.48)  |
| <b>2011</b><br>No.<br>Percent | 48.86<br>(8.05) | 47.06<br>(8.23) | 95.92<br>(8.44)  |
| <b>2016</b><br>No.<br>Percent | 57.36<br>(8.84) | 55.60<br>(9.05) | 112.96<br>(8.94) |

**Source:** Census of India: 1991: Population Projections for India and States 1996 - 2016, Registrar General India, New Delhi 1996.

The table indicates that in absolute terms, the number of aged persons has grown rapidly during the inter-census period. But their share in total population has risen from 5.6 percent in 1961 to 6.7 percent in 1991, only.

According to official projections, this number will rise to 112.96 million by the year 2016, making it 8.94 percent of total population (table 2).

Table 2 also indicates that the number of the aged is likely to increase by 107 percent over the 25 years period of 1991-2016, while during this period the total population is projected to increase by 49 percent only (Visaria: 2001).

## II. Expectancy of life

In India, the process of mortality decline, particularly the infant and child mortality, began in the 1920's. The average length of life of an Indian child in the

1930's was 30-32 years, with the males enjoying anomalous advantages relative to females. It has risen to over 60 years in 1991 with females enjoying an advantage of more than one year over males. The official population projections for the ninth five year plan envisages an increase in life expectancy at birth from an estimated 62.4 years during 1996-2001 to 67.0 during 2011 - 2016 for males. The corresponding values for the females are assumed to be 63.4 and 68.8 years respectively (Visaria: 2001).

Though the Indian experience of mortality decline broadly conforms to the pattern of UN model life tables, the elderly seem to have a slower increase in their life expectancy. Visaria (2001) notes ".....The South Asia pattern of model life tables, for example, implies that with a female life expectancy of 75 years at birth, the expected length of life at age 60 would be 21 years. (However) according to the SRS life table for females 1991-95, Kerala is the only state

in India, which conforms to this pattern. With an expected length of life at birth of 75.6 years, Keralese women aged 60 on an average can expect to live for 20.6 additional years. In the country as a whole as well as in most states, the increase in the length of life of the Indian elderly has been quite slow .

Several explanations could be offered for this phenomenon. Firstly, advantages of mortality decline in India have so far been accrued to younger children of under 5 years. Public health interventions for the elderly have been limited, or their impact has not yet contributed to lengthening of life expectancy of the elderly. Secondly, society and the younger generation are not ready or equipped to cope with an increase in dependency burden of the elderly and in spite of increase in number, there is little change in the provisions for them (Goyal: 1997).

### III. Disease and Disability Burden

Table 3 presents a comparative analysis of prevalence of chronic diseases among elderly men and women at two points of time. The data are drawn from 42nd and 52nd rounds of NSS, and present self-reported prevalence. (Though in self-reporting of symptoms, a tendency of over-reporting has been noted, comparison at different points of time or across sub-groups of population may neutralise this phenomenon and reflect true prevalence).

The table shows that the overall reporting of illness has indicated an increasing trend during 1986-96. In 1986 about 45 percent of rural and 44 percent of urban males reported that they were suffering from a chronic ailment. In 1996, their proportion grew to about 53 percent. Similarly, in 1986 about 45 percent

**Table 3: Percent of Aged Reporting some Chronic Disease According to NSS: 1986-87 and NSS: 1995-96**

| TYPE OF DISEASE   |             |                |                         |       |                     |
|-------------------|-------------|----------------|-------------------------|-------|---------------------|
| Category and Year | Any disease | Heart problems | Pain/problems in joints | Cough | High Blood Pressure |
| <b>RURAL Male</b> |             |                |                         |       |                     |
| 1986-87           | 45          | 3              | 45                      | 36    | 6                   |
| 1995-96           | 53          | 4              | 36                      | 25    | 11                  |
| <b>Female</b>     |             |                |                         |       |                     |
| 1986-87           | 45          | 3              | 51                      | 33    | 7                   |
| 1995-96           | 51          | 3              | 40                      | 20    | 10                  |
| <b>URBAN Male</b> |             |                |                         |       |                     |
| 1986-87           | 44          | 3              | 35                      | 26    | 17                  |
| 1995-96           | 53          | 3              | 28                      | 18    | 20                  |
| <b>Female</b>     |             |                |                         |       |                     |
| 1986-87           | 46          | 2              | 44                      | 22    | 19                  |
| 1995-96           | 58          | 2              | 39                      | 14    | 25                  |

**Source:** NSSO (1991) Sarvekshana Vol. XV No. 2 Issue 49 & NSSO (2000) Saveshana Vol XXIII No. 3 Issue 82, Ministry of Planning, Gol, New Delhi.

rural and 46 percent urban women had a chronic ailment. This proportion increased to 51 percent and 58 percent respectively in 1996.

However, when it comes to specific conditions the pattern of change is mixed. For pain/problem in joints (arthritis) and cough (two most common health problems), there is a declining trend. The proportion of persons suffering from high blood pressure has however increased. The figures for persons suffering from heart problems remained static and ranged between 2 to 6 percent.

Table 3 also notes large rural urban differences in the intensity and pattern of prevalence of major chronic conditions. Firstly, the overall reporting of illnesses was higher among rural people as compared to their urban counterparts.

Further, arthritis and cough were more common among the rural aged than the urban ones. On the other hand a blood pressure problem was quoted by a large number of urban residents.

One of the important findings of Table 3 is the absence of gender specific differences in the prevalence of chronic diseases in old age. Though general reporting was somewhat higher among women, when it comes to specific diseases, prevalence was invariably higher among males. This phenomenon is particularly visible for two

prominent problems of old age i.e. arthritis and cough. Further, this pattern remained unchanged during the decade (1986-96) under observation.

A somewhat similar pattern was noted in the data from NFHS (1992-93) on the prevalence of certain chronic diseases. This survey indicates that a larger proportion of men were reportedly suffering from cough, TB, and malaria than the women. Women had a higher prevalence of joint problems. The difference between the burden of these diseases on men and women was however, very small.

Table 4 presents the analysis of the level of physical disability among elderly persons. Incidentally, these details were not collected in the 1986 survey.

The data in Table 4 indicate that more than one third of the elderly were reportedly suffering from one or other disability. Poor eye sight followed by hearing impairment are the commonest reported disabilities. Locomotion and amnesia (senility) were reported by 6 to 12 percent of elderly persons. Speech impairment was relatively less common. Further, reporting of general disability was more in rural areas than in the urban ones, while specific impairments were reported more by the urban residents.

Table 4 also indicates that though the reporting of physical impairments was somewhat higher among females than males, the difference between the two

**Table 4: Percent of Aged Reporting Physical Disability in India in NSS: 1995-96**

| Category     | Any Disability | Visual | Hearing | Locomotion | Amnesia/Senility | Speech |
|--------------|----------------|--------|---------|------------|------------------|--------|
| <b>Rural</b> |                |        |         |            |                  |        |
| Male         | 38             | 25     | 14      | 11         | 10               | 3      |
| Female       | 42             | 29     | 16      | 12         | 11               | 4      |
| Average      | 40             | 27     | 15      | 11         | 10               | 4      |
| <b>Urban</b> |                |        |         |            |                  |        |
| Male         | 33             | 22     | 11      | 8          | 6                | 3      |
| Female       | 36             | 26     | 13      | 9          | 8                | 3      |
| Average      | 35             | 24     | 12      | 9          | 7                | 3      |

Source: NSSO (2000) Sarveshana Vol. XXIII no. 3 Issue 82. Ministry of Planning, Gol, New Delhi.

was not significant. Only in the case of visually handicapped women was the disadvantage noteworthy.

Data generated by NFHS (1992-93), however, report a distinct male disadvantage in disability burden. Two disability parameters i.e. partial blindness and impairment of limbs show a greater challenge for elderly men than women. Importantly, in all the three elderly age groups (60-69,70-79, 80+) a similar pattern has been noted. Prevalence of complete

blindness was somewhat higher among women in the 80+ age group (IIPS: 1995).

## DISCUSSION

The absence of gender specific differentials in disease and disability burden of the elderly, particularly in the backdrop of a life-long deprivation and discrimination against women in the provision of nutrition, health care etc. raises several questions. Firstly, what are the possible reasons for this

**Table 5: Living Arrangement of Aged in India: 1986 & 1996  
(Percent Distribution)**

| Area and Category | Type of Living Arrangement |                         |                                      |                      |                    |
|-------------------|----------------------------|-------------------------|--------------------------------------|----------------------|--------------------|
|                   | Living Alone               | Living with Spouse only | Living with Spouse and other members | Living with children | Living with others |
| <b>Rural Male</b> |                            |                         |                                      |                      |                    |
| 1986              | 12                         | -                       | 45                                   | 37                   | 6                  |
| 1996              | 2                          | 14                      | 75                                   | 18                   | 4                  |
| <b>Females</b>    |                            |                         |                                      |                      |                    |
| 1986              | 1                          | -                       | 25                                   | 66                   | 7                  |
| 1996              | 6                          | 8                       | 39                                   | 48                   | 6                  |
| <b>Persons</b>    |                            |                         |                                      |                      |                    |
| 1986              | 8                          | -                       | 37                                   | 49                   | 6                  |
| 1996              | 4                          | 11                      | 57                                   | 33                   | 5                  |
| <b>Urban Male</b> |                            |                         |                                      |                      |                    |
| 1986              | 10                         | -                       | 45                                   | 40                   | 6                  |
| 1996              | 3                          | 10                      | 75                                   | 18                   | 4                  |
| <b>Females</b>    |                            |                         |                                      |                      |                    |
| 1986              | 1                          | -                       | 22                                   | 67                   | 10                 |
| 1996              | 6                          | 6                       | 35                                   | 51                   | 6                  |
| <b>Persons</b>    |                            |                         |                                      |                      |                    |
| 1986              | 6                          | -                       | 35                                   | 51                   | 7                  |
| 1996              | 4                          | 8                       | 55                                   | 35                   | 5                  |

**Source:** NSSO (1991) Sarvekshana Vol. XV No. 2 Issue 49 & NSSO (2000) Saveshana Vol XXIII No. 3 Issue 82, Ministry of Planning, Gol, New Delhi.



  
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## MERCK INSTITUTE FELLOWSHIPS



The International Institute on Ageing, United Nations – Malta has received a grant from the Merck Institute of Ageing and Health, Washington D. C. for the years 2003 and 2004 for Training Programmes, which are held in Malta. These funds support the educational activities of 8 Fellows from developing countries participating in the Short Taining Programmes in Social Gerontology, Economic and Financial Aspects of Ageing, Geriatrics and Demographic Aspects of Ageing as well as 2 participants in the 9-month Postgraduate Diploma Course in Gerontology and Geriatrics at the European Centre for Gerontology, University of Malta.

Applications for the above Fellowships will be received by Professor Frederick F. Fenech, Director of the International Institute on Ageing, United Nations – Malta, 117, St. Paul Street, Valletta VLT 07, Malta, e-mail [ffen@inia.org.mt](mailto:ffen@inia.org.mt).

The closing date of applications can be obtained from the Institute's website, [www.inia.org.mt](http://www.inia.org.mt).



phenomenon? The pattern observed for India is quite close to the one observed in the WHO study of 12 developing countries. It notes a longer healthy life expectancy for women in 10 out of 12 countries (except in Tunisia and Egypt) (Kinsella: et.1993). Several developed countries also depict a similar pattern.

In the context of India, possible explanations could be found in the socio-cultural domain of society. In spite of discrimination and neglect, the family institutions provide protection and care particularly, to elderly women. Further, in Indian society, transition to old age provides new opportunities and status to women. They exercise more power in the household as mothers-in-law or grandmothers than they did as younger women. Data on living arrangements of the elderly endorse this point.

Table 5 indicates that relatively a larger proportion of elderly females are either living with children or with spouses along with other members (i.e. children). Though, during the decade 1986-96, a decline has been noted in the proportion of women living with children, it features in the category

“living with spouses and other members i.e. children”. In other words, most elderly women in India continue to live in an environment where they are cared for.

The second question that merits attention is about the future directions. Present analysis shows that the quality of life (in terms of free from problems particularly pain in joints and cough, two major conditions of old age) of the elderly in India has either remained the same or showed improvement during the decade 1986-96. Further, the disability burden due to locomotion and senility, the two crippling problems of old age, is low. It is also evident that in spite of disadvantages in early life (which could have adversely affected their health), elderly women enjoy health status similar to men. Against a backdrop of continuously improving life expectancy of women (as compared to men), it could mean that India is well on the path of the trend observed in developed countries, i.e. a higher healthy life expectancy for women. But this interpretation may be read with caution, as more data, particularly longitudinal data, are required to substantiate it.

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# MEDICINES MANAGEMENT IN OLDER PERSONS

## CONFERENCE REPORT

LILLIAN AZZOPARDI

The International Institute on Ageing, United Nations- Malta (INIA) held a conference on Medicines Management in Older Persons between the 13 and 16 October. The conference was organised in collaboration with the Department of Pharmacy at the University of Malta, Zammit Clapp Hospital, the SIG-Geriatrics of the European Society of Clinical Pharmacy and the Ministry for Health, Elderly and Community Services. Around 90 different health professionals from over 15 developing and developed countries participated at the conference.

Over the past 50 years a revolution in drug therapy has occurred. Today there are a large number of powerful drugs available and it is incumbent on health professionals that these drugs are used rationally and safely. This is an issue in older persons where chronic illnesses are more common than in the rest of the adult population and where concomitant use of a number of different drugs is not uncommon. This is the statement made by Professor Frederick F. Fenech, Director, INIA when he addressed the participants during the opening ceremony.

During the first plenary session on 'The Age Factor in the Use of Medicines' chaired by Professor Roger Ellul-Micallef, Rector of the University of Malta and Head of Department of Pharmacology and Therapeutics at the University, Professor Cameron Swift, from King's College in the United Kingdom, stated that in the United Kingdom the number of prescriptions per head for older persons has increased over the last decade. As a consequence there is a greater statistical likelihood of the occurrence of unwanted drug effects and of potential adverse drug interactions. Also higher demands are placed on the older patients with respect to medication management leading to a greater chance of errors in drug taking. In addition, Professor Swift commented that drugs with well established efficacy

are under-prescribed to older patients often for no valid reason. Workshops and round table discussions were held to discuss these principles with respect to specific disease states such as hypertension, diabetes, heart failure, respiratory disease, and Parkinson's disease. Issues related to drug use in the older persons, namely occurrence of adverse drug reactions, compliance, concordance and patient monitoring, and prevention of falls and fractures were discussed in workshops where the discussions were based on real-life case presentations.

In another plenary session, Professor Carmel Mallia, University of Malta, illustrated the burden of musculoskeletal disorders in older persons. Professor Mallia described the problems faced by the older persons due to pain, reduced function of the affected part, reduced ability to participate in activities and a decline in the quality of life. He emphasised that the approach to addressing these problems is through a multidisciplinary way. During a workshop on 'Prescribing in the Elderly: NSAIDs have they proved their worth?' Professor Mallia presented the current discussion on NSAIDs, particularly the evidence on COX-2 inhibitors and their adverse effect profile. A number of case reports were presented for discussion to identify benefits and safety of these drugs and to identify ways to minimize risks of toxicity.

Kees de Joncheere, from the WHO Regional Office for Europe, addressed the conference during a debate on 'The WHO Essential Drug List in developing countries is a barrier to good older patient care'. Dr de Joncheere stated that the WHO Essential Drug List includes medicines that satisfy the major health needs for the majority of the population and is related to the supply of drugs. This list could be used to extract clinical guidelines, statistical data and pharmaco-economic analysis related to drug use in the older persons. The advantages of the WHO List are that it is an instrument for prioritizing on the use



of medicines considering the financial and logistical restraints that exist in each country. Therefore the WHO Essential List is a tool that is used to select the required and most cost-effective medicines. It is then a responsibility of the country to decide on the number of medicines included on national priorities and on the organization and resources in the health systems. When considering medicines included in the list for use in older persons, factors to be taken into account include formulation and packaging of medicines, pharmaceutical assistance required and possibility of achieving patient adherence to drug regimen.

Professor Georges Zelger from the University of Geneva, Switzerland, lead a Round Table Discussion on the development of drug formularies and protocols on rational drug use for older persons. The multidisciplinary background of the participants provided an opportunity for different perspectives

to be presented and participants discussed their experience with treatment protocols and formularies specifically designed for the care of older persons.

Dr Louis Deguara, Minister for Health, Elderly and Community Services addressed the conference participants during the closing session. The minister stated that with population ageing all over the world, it is essential to identify rational and cost-effective use of medicines in the older persons.

The conference evaluation exercise showed that the participants felt that the conference presented issues which are relevant to their practice and that it provided a forum where they could discuss current practice in the care of the older persons.

The Organizers of the Meeting would like to thank the major sponsors Novartis and GoMobile.



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**UNIVERSITY OF MALTA**



## *INIA Activity*

### **Training Programme on SOCIAL AND HEALTH ASPECTS OF AGEING in collaboration with BEIJING CIVIL AFFAIRS BUREAU (BCAB)**

**08 – 18 October 2004**

Between 8th and 18th October, the International Institute on Ageing, United Nations Malta (INIA) in collaboration with the Beijing Civil Affairs Bureau, (BCAB) Beijing, China, organized a training programme in Social and Health Aspects of Ageing. Twentyfour Chinese Officials from this Organisation working in the field of ageing in various districts of China's capital, benefited from this training which was co-ordinated by Professor Joseph Troisi, INIA's Deputy Director, who also lectured on social aspects of ageing during the programme.

The collaboration between INIA and BCAB in the field of ageing dates back to an agreement signed in Beijing on 22nd March 1999 between Prof. Troisi on behalf of INIA and Madam Zhang Kun Yi, Foreign Affairs Director of BCAB. As a result of this agreement, eight training programmes in the various areas of ageing have been held, four of which were organized in Beijing and the other four in Malta. In all, 267 Chinese officials have successfully completed these training programmed 174 in China and 93 in Malta. INIA is organizing another training programme in China in collaboration with BCAB between 30th October -7th November 2004.

The programme consisted of lectures by local experts and two site visits. As in the past, the group were also received by the President of Malta, His Excellency Dr. Edward Fenech Adami, at the Palace in Valletta. The opening and closing ceremonies were attended by His Excellency Mr. Liu Zheng Xiu, Ambassador to the

People's Republic of China. The Hon. Ms. Helen D'Amato, Parliamentary Secretary with the Ministry of Health, the Elderly and Community Services, addressed the group on the first day. Professor Frederick F. Fenech, INIA's Director, opened the programme and also lectured on health issues in the field of ageing.



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# INTERNATIONAL DIARY 2004 - 2005

**2004**

**DECEMBER 2 - 3 – CARDIFF, U.K.**

Final Scientific Conference on Dignity and Older Europeans

Information: E-mail: [doe-project@cf.ac.uk](mailto:doe-project@cf.ac.uk)

**2005**

**JANUARY**

CICRED – The Impact of Mortality as Both a Determinant and a Consequence of Poverty and Hunger: A Contribution to Achieving the First Millennium Development Goal (Eradicate Extreme Poverty and Hunger)

**February 9 -18 New York, USA**

43rd Session - Commission for Social Development  
Website: <http://www.un.org/esa/socdev>

**March 3 - 4 Bonn, Germany**

Conference on Population and Development Cooperation

**June 26 - 30 - Rio de Janeiro, Brazil**

World Congress of Gerontology (IAG)

Website: [www.aceventos.com.br](http://www.aceventos.com.br)

**June 27 - 29 Trondheim, Norway**

Sixth International Conference - Creative Solutions for an Ageing Society: Sharing the Wisdom

Website: [www.v.iahsa.net](http://www.v.iahsa.net)

**29th September- 1st October St. Gallen, Switzerland**

1st World Ageing & Generations Conference

Website: <http://viva50plus.org>

E-Mail: [http://viva50plus.org](mailto:viva50plus.org)

**30th September - 2nd October Ljubljana, Slovenia**

XVIII International EURAG Congress 2005

Website: [www.eurag.europa.org](http://www.eurag.europa.org)

**November 17 - 20 - THESSALONIKI, GREECE**

2nd International Congress on Brain and Behaviour

Information: <http://www.psvchiatry.gr/intro-brain2-erg.html>

## INIA'S DIARY 2005

**2005**

**23rd January - 2nd February**

In-Situ Training Programme in **GERONTOLOGY AND GERIATRICS**, (BELARUS)

**7th - 18th February**

International Short Training Programme in **SOCIAL GERONTOLOGY**, (MALTA)

**28th February - 11th March**

International Short Training Programme in **ECONOMIC AND FINANCIAL ASPECTS OF AGEING**, (MALTA)

**21st – 30th March**

In-Situ Training Programme in **GERONTOLOGY AND GERIATRICS** in collaboration with The St. Petersburg School of Public Health, **St. Petersburg** (RUSSIA)

**16th - 27th May**

International Short Training Programme in **GERIATRICS**, (MALTA)

**September**

In-Situ Training Programme in **GERONTOLOGY**

in collaboration with the Singapore Action Group of Elders (SAGE), (SINGAPORE)

**Oct 2005 - June 2006**

International **POST GRADUATE DIPLOMA IN GERONTOLOGY AND GERIATRICS (Dip.Ger)**  
European Centre of Gerontology and Geriatrics, (University of Malta), (MALTA)

**October**

In-Situ Training Programme in **GERONTOLOGY** in collaboration with the Beijing Civil Affairs Bureau (BCAB), (HUAIROU)

**7th - 18th November**

International Short Training Programme in **DEMOGRAPHIC ASPECTS OF POPULATION AGEING, POLICIES AND ITS IMPLICATIONS FOR SOCIO-ECONOMIC, POLICIES AND PLANS**, (MALTA)

**5th - 16th December**

In-Situ Training Programme in **GERONTOLOGY AND GERIATRICS** in collaboration with Caisse Nationale de Securite Sociale (CNSS), Tunis (Tunisia)

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## *INIA Activity*

### **International Short Training Programme in Demographic Aspects of Population Ageing and - its Implications for Socio-Economic Developments Policies and Plans.**

6 -17 September 2004

The International Institute on Ageing, in collaboration with UNFPA and the University of Malta, for the 11th consecutive year organised an International Short Training Programme in Demographic Aspects of Population Ageing and its Implications for Socio-Economic Development, Policies and Plans. The programme which was held at the Forum Hotel, St. Andrews between 6 - 17 September 2004, was opened by the Hon. Ms. Helen D' Amato, Parliamentary Secretary Ministry of Health, the Elderly and Community Care.

The programme, designed by an International Expert Group and co-ordinated by Dr. Julian Mamo was geared towards: achieving a working knowledge of demographic concepts and techniques; acquiring the methodological approaches, tools and techniques in demography adopted in assessing the conditions of the elderly at global, regional and country level; gaining an ability to convey information effectively to policy makers. This intensive two week programme included lectures and hands-on computer sessions. Besides, the participants presented a final report at the end of the two week programme.

Apart from local experts, lecturing on the programme were Dr. Nikolai Botev, Demographer from the UN Economic Commission for Europe in Geneva and Dr. Kevin Kinsella, Special Assistant at the Bureau of the Census, Washington, USA.

This year INIA received an extensive number of applications from potential participants seeking fellowships to attend the programme in Demography. Fourteen participants hailing from Cuba, India, Kenya, Nepal, Palestine, Philippines, Romania, Russia, South Africa, Turkey, Vietnam and Zambia participated. Two participants were granted an MIAH scholarship from the Merck Institute of Aging and Health, Washington D.C.

The closing ceremony of the programme which was held at the International Institute on Ageing (INIA), was addressed by the Hon. Dolores Cristina, Minister for the Family and Social Solidarity in the presence of Hon. Ms. Helen D'Amato, Parliamentary Secretary Ministry of Health, the Elderly and Community Care and INIA's Director Professor Frederick F. Fenech.



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