Malaysia's Ageing Issues

J T Arokiasamy, SM, Department of Social and Preventive Medicine, Faculty of Medicine, University of Malaya, Kuala Lumpur

According to United Nations estimates, the population of the elderly 60 years and over in the world will reach 1.2 billion by the year 2025, the majority of whom will be in developing countries[1]. A major factor in the ageing of a population is fertility decline and statistics indicate that fertility for Malaysian females has been declining[2,3]. The implementation of development and health programmes along with the general improvement in the standard of living has also brought about remarkable decline in mortality which also contributes to the ageing phenomenon. The expectation of life at birth has increased for both sexes in all the ethnic groups. There are gains also, though small, in the expectation of life at 60 years of age for all the ethnic groups except in the case of the Indian male who has not had an increase compared to the figures for 1957. The population who are aged 60 and over in Malaysia is estimated at about 1 million now, and is projected to increase to 1.5 million by the turn of the century, and 4 million by the year 2025. Using the more conventional measure of 65 years and over, the number of persons aged 65 and over is estimated at around one million by the year 2000, and 2.7 million by the year 2025[2,3]. There will be 833,000 old-old (aged 75 and over) in just about 28 years from now[2]. The growth pattern of the different age categories indicate that while increases in all age categories are expected, the increase is more marked at the older ages. Further, the drive towards industrialization has attracted many young people to work in industries which are located mainly in urban areas and usually away from their rural family homes. This out migration of young persons from rural areas has contributed to a breakup in the extended family structure and aggravated the ageing of the population in rural communities[2].

Ageing is distinguished from disease by the fact that it is universal. Multiple pathologies resulting in multiple symptoms, often non-specific, are a common phenomenon in the elderly[4]. Disabilities[5] and frailty[6] are common among the elderly in Malaysia and have been found to increase with age. This rise with age has implications on future service and care requirements as the absolute numbers of disabled elderly will increase with the growing population of the elderly. Illnesses in the elderly tend to be chronic, the more common ones being cardiovascular disease, cerebrovascular disease, neurological problems, musculoskeletal problems, urinary and fecal incontinence, injuries from accidents, visual and hearing losses, dental deficits, psychosocial problems, depression, dementia, and foot problems. Incontinence as a problem among the elderly is increasingly being recognised. For the family and other providers of long term care, coping with the incontinent patient is a tedious and time consuming task, that, in the case of family members, can also strain the personal relationship. To the patient with this problem, it is embarrassing, depressing, enhances social isolation and dependency on others[4]. Among the mental health related problems, Alzheimer's disease too is an increasingly recognised problem, though the actual extent of the problem in Malaysia is unknown. It is the most common form of dementia affecting possibly at least 5% of the population over 65 years of age and is associated with a marked decrease in life expectancy[7]. The disease is a progressive and unremitting, and the mainstay of treatment is good nursing of the patient and skilled support of the spouse and relatives. Alzheimer's Disease has important implications for the country's future resources as the chronicity of the problem and the absolute numbers faced will grow as the number of elderly increases. Changes in dietary patterns among the elderly due to changes in the gastrointestinal system as a result of the ageing process, poor dentition, and types and amounts of food purchased result in gastrointestinal problems such as constipation and nutritional problems. Since nutritional status of an individual and

susceptibility to infection are related in a vicious cycle, undernutrition in the elderly can affect their ability to handle infections[4].

The under reporting of symptoms is not uncommon in the elderly despite the availability of a comprehensive health care delivery system, with the consequence that serious problems are often unknown or not treated[4]. This may occur due to the view of the elderly that illness, loss of independence, feeling sick, and old age are related. Other reasons may be concealment of symptoms due to a fear that something would be found, which when treated would produce functional loss and jeopardise independent living. The ignorance of gerontological information in both the elderly and among the carers and attending health workers is an issue that needs to be considered when developing preventive programmes for the elderly. Another issue that needs to recognised is that the health care system is basically passive with the carer or the elderly seeking treatment when symptoms develop[8]. It has to be recognised that the elderly often cannot be relied upon to initiate appropriate, timely health care for themselves, especially early in the course of an illness when treatment or intervention may have a favourable outcome.

Chronic problems require long term management which has implications. The health care system has been developed to focus on short term care and short term hospitalisation with the consequence that the services available may not be effective in dealing with elderly having chronic diseases and disabilities. It has been reported that physician visits among the elderly are known to increase with age. On the other hand dental visits are relatively constant over the age groups and lag behind physician visits[9]. This is possibly due to the lack of financial ability to afford dental care.

With cost of hospital based care increasing and available resources being limited, health planners are placing emphasis on prevention and primary health care. Singapore, Hong Kong and Japan have home nursing services but the supply apparently is inadequate to meet the demands. There also appear to be variations in subsidised medical care available to the elderly in the Asian region[10]. This varies from introducing a programme of free medical care for persons aged 60 years and above in country hospitals of Thailand, free health screening services to elderly persons by the municipalities in Japan, medical treatment at nominal costs to the elderly in Hong Kong hospitals, to the Medisave programme in Singapore since 1984[10]. It is possibly true that presently in Malaysia, health care is more widely available than are pensions, although the adequacy and accessibility of care are uneven. Malaysia has comprehensive medical and health care services for the general population, but special programmes for the aged are lacking, including geriatric services. Geriatric medicine as a specialised field has not developed adequately in Malaysia as yet. Policies directed at providing appropriately trained medical and health personnel who can deal with elderly patients will be needed. Medical and other related curricula should be changed where necessary to give geriatric medicine recognition.

A healthy lifestyle that would benefit the elderly is recognised and programmes to inculcate healthy lifestyles have recently been introduced. A healthy lifestyle may enable the young of today to continue to do so into the future when they move into the elderly category. This would minimise the occurence of illness and the occurence of disabilities. Good health maintenance in early life and later years via a healthy lifestyle, avoiding smoking, prudent diet, and regular exercise can help the social and cultural life of the elderly, including fewer physician visits, and fewer medications taken. Moreover the common activities of daily living can be maintained enhancing the independence of the elderly.

Non health factors

The elderly are a heterogeneous group whose health is affected by several non-medical factors too which include work, retirement and income, housing and institutionalisation, family and the community, lifestyles and leisure activities, and personal characteristics such as gender, ethnic background, personality, and widowhood. Along with medical and health factors, these other factors too play a role in the quality of life of the elderly. The aim in maintaining the quality of life of the elderly is to assist them to have a full life for as long as possible. With increasing numbers of elderly and the increased expectation of life, the particular concern is the quality of life in the extra

years[11]. The elderly would have to have equal rights to others, which include an adequate income, the right to work, the right to choose where to live, the right to be involved in decision making regarding their own life, having access to resources, and the capacity to function independently.

Socioeconomic security contributes to quality of life of the elderly. In fact, level of income and health status are the two most consistently found variables associated with life satisfaction among the elderly[12]. Work is an important factor in keeping the elderly healthy. While presently there may be a conflict of unemployed youth competing for jobs and the old wanting to go on working after compulsory retirement at age 55 years, this may give way in the future. In the long run with ageing of the population, the ratio of people working to those retired can be expected to fall. In Japan this ratio of 6:1 in 1990 is expected to fall to 3:1 by 2030[11]. The consequence of this is a shortage of wage earners that could be met by increasing the number of women in the work force and older people beyond the present retirement ages being available for work. Continued employment is associated with higher morale, happiness, better adjustment, longevity, larger social network, and better perceived health among the elderly. There are therefore merits in keeping the elderly in the workforce if this will keep them healthy longer and avoid seeking health care[11].

Women survive longer than men, tend to be lonely, are economically disadvantaged and usually end up caring for and nursing infirmed elderly in the household[13]. However this is being influenced with the increased tendency for women to enter the labour force on a full time basis or being geographically isolated from their elderly parents. This can be of concern in the future health care of elderly in Asian countries.

Mortality rates in the elderly are lower if they are married compared to higher mortality rates among the single, divorced or widowed. In countries such as Korea, Malaysia and the Philippines, the family continues to be the single most important source of support for the elderly and filial piety continues to play an important role[11,12]. However elsewhere, there is a tendency for elderly to enjoy close family ties yet preferring to be independent from the family, as has been observed in Canada, Japan and Germany[11]. In Japan this has similarly been seen, but institutionalisation is not favoured among the elderly unlike their counterparts in other western developed countries[11]. If temporary or permanent institutionalising is to occur, relocation planning is important. There should be a caring approach to this and positive support provided especially by the family. Preferably the decision should be made by the elderly person[9].

Education plays a key role in the care of the elderly for the quality of care provided is often a result of our opinions about them which are molded by our culture, traditions, personal experience, education and training. As attitude and behaviour patterns take time to develop, it is necessary to educate people from young so that when they grow up they will enjoy a more satisfying life. The community can offer education programmes not only for the elderly but also for families, carers, the young, policy makers, planners, politicians, and service providers. This would facilitate an understanding of problems and difficulties faced and the support and resources available in the community for the elderly.

Community programmes are important in the care of the elderly[14,15]. Chen *et al*[16] following the results of the WHO study, recommended that day care centres, home care services and respite care be developed through health centres, local councils, district hospitals and voluntary organisations. This will be helpful to families with elderly members. The community in turn could provide *pondoks,* companionship, meals on wheels, counseling, and support in crisis. An important community based service of relevance is the provision of home nursing. This service is now a well established programme in Singapore[10],the mission of which is to provide health service for the non-ambulant and aged sick to help them be cared for in the community for as long as possible. Through its services, home nursing ensures the continuity of health care for hospitals especially when patients are discharged. An important function also of this service would be to train community members including family members, neighbours and friends to take care of their elderly at home.

Activities of senior citizen clubs play an important role in keeping the elderly healthy. They promote group life

and community service that can help overcome loneliness and hence the establishment and activities of these clubs need to be encouraged[17]. Other areas that need attention too include housing designs, transportation subsidies beyond what is available presently, and strict regulation of nursing homes so that the elderly and their families are not exploited. The recent Act relating to Care Centres is directed at, among others, controlling the nursing homes. However, coordination is necessary in enforcement, with the Ministry of Health playing a lead role on the medical aspects of the Act, and the Department of Welfare Services taking the lead on non-nursing aspects. The recently established National Council on Elderly is a step in the right direction, as its membership is multidisciplinary in nature. A National Policy on the Elderly has already been drawn up, but the challenge is to implement the strategies and programmes rapidly to meet the needs of a rapidly growing elderly population.

Conclusion

Meeting the needs of the elderly within available resources while maintaining the efforts to industrialise the country by the year 2020 is indeed a challenge. This inevitably requires a sharing of responsibilities between the government, the private sector, non-governmental agencies and the community. The complex nature of problems faced by the elderly requires a multisectoral and multidisciplinary approach to set up policies, programmes and activities relating to areas such as housing, education, transport, taxation, and income security that will improve the quality of life of the ageing population and promote healthy ageing. This would require coordination and linkages between policy planners, administrators, service deliverers, and the research community; between formal and informal care systems; and between individuals and groups of older adults. Planning, development, delivery, and evaluation of services and activities provided will need the availability of strong data bases and relevant research. Importantly the elderly must remain integrated in society and themselves must have a say in the formulation and the implementation of policies that directly affect their well-being, while sharing their knowledge, skills and wisdom with society, and in particular the younger generations.

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