Social Problems and Care of the Elderly

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Introduction

Several countries of Asia, including Malaysia, have in recent years experienced spectacular economic growth and social change. This, together with declining fertility rates and mortality rates, and accompanying increased expectation of life at birth have resulted in rapid population ageing of these countries. However, relative to the developed countries, where fertility and mortality declines, and improvements in social and economic conditions have evolved gradually over a period of a century, these phenomena in the developing countries of Southeast Asia are evolving in a much shorter time period aided by the availability of medical and technological advances and interventions that can prevent deaths and births and prolong the duration of disability free years of life. This poses a challenge to countries like Malaysia who have to cope with the ageing phenomenon with limited resources that are available.

The elderly are a heterogeneous group who are affected by both health and non health factors. The latter are largely social factors related to health that contribute to social problems faced by the elderly. This paper addresses these before looking at the care of the elderly.

Social Problems and the Elderly

At the outset it is important to recognise that the relationship between the social state and health state is nowhere more important than amongst the elderly[1]. To lead an independent life, the elderly need some basic requirements and skills for day to day living that include the ability to undertake social activities, and perform personal and domestic tasks. Activities of daily living address these three aspects which are inter-linked. In the elderly, according to Williams[1], with the passage of time, deterioration tends to occur first with sociability, followed by breakdown in carrying out domestic tasks and finally in personal tasks. A medical practitioner must be aware that social problems can set in with the onset of an acute illness episode or injury which are often reversible with appropriate treatment.

However, with chronic disease problems, which develop gradually, the changes that occur are not so readily reversible requiring social and other support interventions to complement the treatment of the disease.

Few elderly persons escape the accumulation of chronic pathologies as they grow older. Consequently, multiple pathologies resulting in multiple symptoms are a common phenomenon in the elderly[2]. A number of chronic conditions often occur simultaneously at different levels of severity. Thus an accumulation of long term non-fatal diseases is common in the elderly, many of which are degenerative in nature. Several health problems relating to smoking, alcohol consumption and eating habits too contribute to reducing the number of disease free years of life experienced by the elderly. The many health problems faced by the elderly result in functional, psychological and social disabilities. Functional disabilities result in restricted activity days, work loss days (if working), bed disability days, social isolation, reduced vigorous physical exercise, drop in activity tolerance, weakened muscles, bone loss and, feeling of physical incompetence[3]. Psychological disability can result in loss of confidence, exaggerated withdrawal from unusual activities, feeling of physical incompetence, depression, anxiety, hypochondriasis, sleep disturbances, suicidal tendencies. Social disabilities as a result of these chronic problems affect family relationships, worse in nuclear families and if the elderly is living alone in widowhood. Institutionalising for acute intercurrent problems or long term care can occur too[3].

Economic Aspects

Economic aspects play an important role in the lives of the elderly affecting their health, social relationships, living arrangements, community activities, and even political participation[4]. Their daily opportunities and competence is influenced by their employment, retirement and income. Employment patterns in the past and present affect their economic status. With increased participation of women in the labour force, the issues relating to employment, retirement and income are as relevant to them as they are to men.

A World Health Organisation (WHO) study[5] and the Malaysian component of an ASEAN study[6] revealed that the aged, particularly in rural areas, continue to work till even when they are 75 years of age or older. The studies revealed that about 70% of males 60-64 years of age felt that the elderly should be active in work, while about 40% aged 75 years and over desired the same. The need to remain in work is a real desire in the elderly and society does have a responsibility to consider this seriously. A sizeable proportion of the elderly in Malaysia (professionals, scientists, scholars) still maintain a high level of mental acuteness and hence, are able to contribute to society[5]. However there can be obstacles in elderly seeking employment as job searches can prove to be frustrating especially if they have been in one type of occupation for a long period of time and therefore lack experience in other areas. Their skills may also become obsolete, or are intimidated by new technology, or worse of all, they have to overcome negative stereotypes about ageing and productivity among employers[4].

Retirement is a normative expectation of old age. Increased longevity means both men and women are spending more years in employment and enjoying a longer period of retirement. It is a major transition in life, and if compulsory, it has implications especially on the ability to work. Chronological age rather than ability to work is the basis for retirement. The consequence of retirement is that it leads to loss of the role as a worker or producer, and as an income provider. These result in loss of status, self-esteem, made worse if there has been no pre-retirement training.

The elderly are dependent on work, pensions, savings, provident funds, etc. to meet their financial obligations, as well as the cost of health care. The need to supplement pension income appear to be the greatest motivation for seeking employment after retirement, though the need to feel productive and to share their expertise may also be reasons. Factors, such as, home ownership saves on rentals, but outstanding mortgages and costs of repairs can deplete their financial resources.

Extended life expectancy especially in older poor women puts them at risk of poverty. Financial pressures cause grief and anxiety to the elderly, and this is aggravated by inflation and rising health care costs. The loss of income or inadequate financial resources that results in financial disability may result in the elderly delaying seeking health care in order to conserve their resources. This is a possible factor in reluctance to seek care for visual, hearing and dental problems. Moreover, the elderly tend to also change their living styles, and drop out of social groups especially when they face transportation problems as a consequence of financial constraints.

Residential Aspects

The old prefer to live in their own homes, and in their familiar neighbourhood. Housing at present is being rapidly developed throughout the country, but usually with only the nuclear family in mind. To many the emotional meaning of home in terms of history, of family life (marriage, child rearing), and association with friends and neighbours is important. Because of this some elderly may not want to move even if frail and mobility impaired. This is especially so if the elderly have not been involved in the decision to relocate. However, circumstances may arise that require the elderly to be relocated as when they have to move to be with their children due maybe to failing health.

Institutionalisation is a risk that the elderly face. Institutionalised elderly often experience excess morbidity and mortality and this is aggravated if they are not the ones making the decision[3]. The lack of adequate contact with family and friends and the tendency for excessive custodial attention can result in the institutionalised elderly being depressed and

withdrawn. Financial or fiscal disability is a problem the elderly face when institutionalised. Considerable anxiety and grief results from worrying about the costs of their institutionalisation, especially if they are using their personal resources[3].

The Family and The Community

To cater for the happiness and future of the elderly both the physical and emotional needs of the elderly must be met. For most elderly their families are the most important source of support[5-6]. The changing family structure from an extended family towards a nuclear family has reduced the extent to which support is available, especially at times of need. The increased participation particularly of women in the labour market has contributed to this as these children are not available for help all the time unlike the past. The rural urban migration which has led to the ageing of rural areas has made the elderly in rural areas vulnerable. Other vulnerable groups are primarily widowed elderly women and the very old who have outlived their other family members. It has been seen that the extent of familial support declines with urbanisation and industrialisation especially in urban areas though it is not expected to disappear, The spouse is often the primary support person through companionship, and being available as a confidante. With increases in life expectancy at birth, more older partners end up caring for each other, often for long periods More women end up in this role. As much as 60% of primary care givers to older people are wives of disabled, often older husbands[7]. These care giving women often experience loneliness, isolation and role overload. They have a 24 hour responsibility besides coping with their own ageing, physical illnesses, or financial and legal burdens, all of which can create stresses. The loss experienced when the spouse dies poses problems. This is particularly so for the women who outlive their male counterparts. Children too are involved in support but demographic changes towards smaller families may result in they being unavailable or able to share the responsibility around. In this situation siblings come in to supplement the support but it has to be anticipated that in the long run with fertility declines there may be fewer siblings to rely on[8].

The family too is the basic institution where norms of behaviour are inculcated into the child. Values and customs are transmitted through the family system in which respect for one another is propagated. It is through constant care and love that the child learns to offer, to share and to experience a cohesive and harmonious life with the elderly. This bond of attachment must be strengthened so as to ensure that the children will continue to care for the parents in their old age. However, when parents have placed their career and success above that of the emotional needs of their children, they find no time for family interactions. This leads to the breakdown in the bond of relationship between parents and their children. In this situation it can be expected that traditional filial piety of their children towards the elderly in such families will breakdown[9].

Respect for the elderly is not only the responsibility of individual families but is also a society's function to promote such respect. Care of the elderly by the family is generally in line with society's norms and sanctions. A community that treasures and values the aged will have little problem in getting their families to look after them[9]. Generally in societies and particularly rapidly modernising ones, attitudes towards the elderly in general tend to be negative. As a result of this an issue that is of concern is the abuse of the elderly. Implicated in this are family, relatives, service providers, and society. The types of abuse include verbal, physical, psychological, and financial. The quality of care provided to the elderly is also a result of our opinions about them which are moulded by our culture, traditions, personal experience, education and training. There is therefore a "national" attitude to the elderly that may tend to be negative. It is this that often reflects the inadequate allocation of resources resulting in poor care, rather than a shortage in money, equipment and personnel.

Loneliness is not uncommon in the elderly and compounds health problems. It frequently combines with physical and mental inactivity. It is encountered by both those living alone or not alone in a family. In the latter it is often encountered in small families especially when the children are away. Living alone promotes privacy, independence and dignity for the elderly. This is not a problem for the elderly if

isolation is avoided. Isolation can be a serious problem in medical emergencies where late treatment could lead to disability, handicaps and even death[10]. There is also the fear that living alone exposes them to crime. Fear of going out coupled with mobility difficulties often aggravates their problems.

Leisure activities are important to the elderly. While those who have had leisure activities prior to retirement will be able to carry on with these or even develop new ones, those who have not had leisure activities before face problems developing new ones when they retire. This leads to these elderly finding it difficult to fill their time that could lead to 'psychosocial' problems in the long run especially if there are no other activities to keep them occupied such as a job or caring for grandchildren

Care Issues

In the care of the elderly, maintaining quality of life and optimum health status are important. Optimum health status can be attained when basic needs of the elderly are appropriately and adequately met. These include[10] living as long as possible; to have protection from too much exposure to physical hazards; to safeguard/strengthen any prerogatives acquired in middle-life such as skills, possessions, rights, authority, prestige etc; to remain active participants in the affairs of life in either operational or supervisory roles; and to withdraw from life when necessity requires it: as timely, honourably, and comfortably as possible.

Community Care

Living in the community and receiving community based long term care are advantageous to the elderly. This is because the elderly can exercise varying degrees of self care; it facilitates the old to identify their own needs and make decisions; they are more likely to have family members, neighbours, and friends who can perform essential tasks for them; they may receive various types of voluntary services and help, there is improved morale; less social dysfunction; better adjustment; and less disability.

Community services refers to any service offered by members of the community and/or Government that enables individuals to remain in the community and out of institutional care[11]. They include day centres, day hospitals, social clubs, rehabilitation centres, counselling and advice centres, transport services, home help, meals on wheels, mobile libraries, volunteer schemes and home nursing. The mission of home nursing 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. It is important to also train community members including family members, neighbours and friends to take care of their elderly at home. Respite care services too can be set up for providing nursing and personal care for the elder who is convalescing or is temporarily unable to maintain himself in his own home. This allows the family a short break to recuperate emotionally from the continual care of the dependent elders. Senior citizen clubs too are already playing a role in keeping the elderly healthy and providing recreational activities. This encourages group life and community service that can help overcome loneliness.

Family Support

Support for the family to encourage meaningful group relationships and interactions are important. Income tax relief has been instituted through allowable deductions for expenses incurred in treatment costs for parents. However, more needs to be done in the form of additional income tax relief, and provision of housing units for elderly parents in the vicinity of family housing units. With social changes such as, migration, urbanisation, increased participation of females in the labour force, changes in family structures, the rapid increase in the number of aged expected in the future and the longer expectation of life, the numbers of the aged that would require institutionalisation can be expected to increase. The existing institutions for the aged will not be adequate to meet this expected demand in the not too distant future, and hence more institutions for homes for the aged would be required. However, to keep this to the minimum, innovative efforts to develop housing programmes for the aged that would enable children to keep the elderly with them or in the neighbourhood, would have to be developed.

Housing Architecture, Environmental Designs and Town Planning

Designs of houses should take into account the structural suitability for elderly people. Facilities within the house should be easily managed with as little help from others. Adequate lighting; storage space being brought to within reach of the elderly, and installing railings and grab-bars are some measures that go a long way in assisting the elderly and minimising the risk of accidents and disabilities that follow[3]. Environmental designs must keep the elderly in mind to prevent accidents among the elderly, for they have poor vision, lowered hearing levels, and slower reaction times, including time taken to cross streets at traffic lights.

Town planners have a major responsibility to keep the needs of the elderly in mind especially when long-term plans are being developed. In the urban areas, accommodation for the elderly should be near shops and clinics and, transport should be available to enable the elderly to have easy access to facilities needed by them. Transportation is vital as mobility of the elderly is a major factor which prohibits them from getting to work or to social gatherings[3]. The public transport system should be reviewed with the objective of providing better and safer facilities for the elderly. Discounted train and air travel now available to the elderly, could be extended to travel by buses.

Education

The community can offer education programmes which are specifically designed for the elderly such as opportunities for learning new skills, adapting themselves to living and working conditions, prevention of accidents, use of leisure, general health, adjustments to the inevitable changes and coping with reduced income. Pre-retirement seminars and courses should be made available to assist the elderly on financial planning, health maintenance, recreation, and time management, so that successful retirement is achieved.

The family and voluntary workers should be informed on how to cope with the problems of the elderly and to provide knowledge on facilities and resources available in the community to strengthen the family's desire to keep their elderly relatives at home[10]. Policy makers, planners, politicians, and service providers too need to be educated so that they can view the elderly positively. They need to understand the ageing process, the needs of the elderly, and perceive them as fellow human beings with common feelings and needs as others.

Work

Job opportunities through sheltered workshops and cottage industries where the elderly can work at their own pace assisting the elderly to adjust themselves to new job situations[9]. Malaysia, as it moves into industrialisation, should tap the wealth of experience and wisdom accumulated over the decades by the elderly, especially the professionals and top management personnel. This will be of mutual benefit to the elderly and the nation.

Health Care

Primary prevention should not be directed solely at the elderly but also at all other age groups as well, so that the benefits gained when young will facilitate healthy ageing. Healthy ageing depends on health promotion, and disease and injury prevention. A healthy lifestyle, is an important thrust of health promotion. Good health maintenance in early life and later years via a healthy lifestyle, avoidance of smoking and alcohol, prudent diet, and regular exercise can help the social and cultural life of the elderly, including fewer physician visits, and fewer medications taken. Health education and counselling must be provided at all opportunities that ageing is not a disease, and that early treatment can prevent disability. Regular and planned fitness programmes are important not only in primary prevention but also in tertiary prevention during rehabilitation after chronic disease has occurred e.g. stroke, diabetes mellitus, cardiovascular diseases[2]. Nutrition education should be carried out regularly as it is important to prevent nutritional problems[10]. There also has to be frequent monitoring of an individual's unique quantitative nutritional needs and intakes, as this can keep changing.

Self care, which is a form of self management, is achieved when the elderly routinely initiate and perform daily living activities on their own behalf in order to sustain life, maintain health, and promote

their well being. The elderly require motivation and they need to develop practical skills to care for themselves. The extent to which self care is practised varies with each individual; is dependent on the elderly's cultural background and values; and is influenced by one's environment.

Secondary prevention involves the systematic detection of precursors of diseases, and is concerned with slowing down the disease process once it has begun to prevent occurrence of other problems, complications or deterioration. Once the disease has occurred, secondary prevention is invoked through measures to detect illness early, for example: diabetes mellitus, hypertension, and instituting early treatment so that the occurrence of disability is avoided or minimised.

Active case detection is necessary, directed at elderly living alone, those widowed, elderly in nursing homes, those recently discharged, the very old, those with known chronic disabling conditions e.g. stroke, parkinsonism, arthropathy, and those dementing or with a history of depression[12]. Regular and frequent periodic medical examination can detect conditions that lead to chronic conditions so that early treatment is effective. All signs and symptoms during these visits, however vague, non specific or unimportant they are to the patient, must be paid attention to, as these may be an indicator of something more serious in the old. Incontinence, visual and hearing problems should be actively sought for, so that, this can be managed early for the benefit of the elderly and his social life.

Rehabilitation is the cornerstone of tertiary prevention involving illnesses that have occurred, with the intention to limit further deterioration of the condition, and prevent further complications or relapses. Tertiary prevention seeks the restoration function so that there is increased ability to achieve work, independence in self care, and self respect. In the case of the elderly, the health care services will have to actively seek out disabled cases so that appropriate intervention can be instituted. The intervention in tertiary prevention has to be a co-ordinated multi-disciplinary effort involving medical, surgical, educational, vocational, and social disciplines.

Terminal care is relevant for elderly who are dying. Physicians and other health workers have a responsibility and professional duty to deal with terminal care of the elderly, with the same enthusiasm and use of clinical skills as when they deal with problems that confront them in other age groups[10]. Good terminal care is concerned with maintaining the elderly's dignity, which involves freedom from physical suffering, maintaining peace of mind, maintaining as much independence as is compatible with physical disability, and flexibility in the care pattern. It is also concerned with respecting the feelings and wishes of the elderly and his/her relatives. This involves trying to attain a blend between clinical priorities and patients wishes. Care has to be taken not to "medicalise" death, for if we do, we neglect the philosophical, psychological, religious, and social aspects of death and dying. In the case of institutionalised elderly who are close to death, there is increase in the problems relating to social death as the patient is often unable to communicate his/her feelings and hopes, as those around are not confidantes. Therefore, the elderly is unable to adapt to his situation, facing a suffering that is unnecessary. Consequently, the process of dying in such cases is unproductive and meaningless as the carers in the institution and the relatives cannot learn from it, with the result that existing fears and feelings are carried on to the next generation. This should be of greater concern as it is increasingly becoming common for professional staff to become a substitute for the family and take over their tasks[10].

Conclusion

The ageing population is both a sociological and medical problem that can easily be neglected in relation to other current and more pressing problems within the country. The needs of the elderly need to be addressed and planned for especially as a long term measure within the context of the countries available resources. At the national level, society is often faced with decisions on what resources it is willing to commit to reduce disability in old age and improve and maintain the quality of life of the elderly. Those in the working group may resist diverting available resources for those elderly who are non-productive. On the other hand, it is also known that the elderly can become a strong political pressure group that can influence legislative action. This will become more

apparent with the increase in wealth that follows industrialisation of a country.

To ensure equal access to resources for all, there needs to be improved co-ordination and communication at all levels (administration) in developing policies; implementation of programmes, with voluntary and the private sector as partners, and a multidisciplinary approach, with involvement of professional organisations and individual professionals. There should also be linkages too between policy planners, administrators, service deliverers, and the research community; between formal care systems and informal care systems, and between individuals and groups of older adults.

Research into the needs of the elderly should be given priority, as overcoming problems of the elderly will improve their quality of life and thereby reduce their dependency on government and society to care for them. Strong national data bases on need for services, use of services, and process of ageing will be useful for accessing research data to assist planning, development, delivery and evaluation of effective services.

The values of a caring society have to be inculcated from young so that positive attitudes of the elderly prevail. This will ensure the elderly themselves as well as their carers and others dealing with the elderly, will view ageing in the correct perspective so that healthy ageing becomes a reality.

Finally, caring for the elderly will require careful forward planning even if we want to ensure that our elderly are to enjoy a satisfactory quality of life, free from poverty, loneliness and ill health. Health promotional and preventive measures that include good and adequate housing, adequate recreational activities, reduction of physical and mental strain, opportunities to work, an efficient geriatric service and adequate welfare services, will play an important role directly and indirectly to keep disabilities low. The responsibilities for these activities will have to be shared by the government, the private sector, non-governmental agencies and the community.

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