ORIGINAL ARTICLE

How Should Malaysia Respond to its Ageing Society?

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SUMMARY

As Malaysia ages its health and social care systems will have to adapt to a changing pattern of disease and dependency. Improved public health measures extend life expectancy at the relative expense of increased prevalence of currently incurable conditions such as dementia and Parkinson's disease. In this article we discuss how these demographic changes will impact and suggest possible means of coping with the altered epidemiology of disease and disability. Malaysia will need to swiftly develop sufficient expertise in acute Geriatric Medicine, rehabilitation of older people; the management of long-term conditions in older people with multiple complex problems within Primary Care; as well as an infrastructure for home and institutional care.

KEY WORDS:
Older people, Elderly, Malaysia, Ageing, Geriatric Medicine, Primary Care

INTRODUCTION

The world is ageing and Malaysia is no exception. The total population of Malaysia increased by an average of 2.6% per annum between 1980 and 2000 and continues to grow at a similar rate (2.4%)[1]. In 1991 the proportion of the Malaysian population aged 65 years and over was 3.7% and in 2000 was 3.9%[1]. Current (year 2008) estimates are that out of a total population of some 27.7 million, approximately 1.2 million Malaysians (4.2%) are aged over 65 years[1,2] . Improvements in nutrition and public health, reduced perinatal mortality, coupled with advances in medicine have contributed to an increased life expectancy and to the demographic changes in this country. Whilst chronological age may not demarcate biological old age, 65 years and over provides a convenient benchmark for demographers; as despite the relative good health and vigour of many of those aged over 65 years, this age group are more likely than any other to suffer from multiple chronic degenerative diseases. Indeed, recent UK data showed that life expectancy increased at a faster rate than healthy life expectancy (expected years of life in good or fairly good health) such that the total expected time lived in poor health rose from 6.5 years (M) and 10.1 years (F) in 1981 to 8.7 years (M) and 11.6 years (F) in 2001 (Figure 1)[3]. Between 1981 and 2001, whilst healthy life expectancy at age 65 rose by 1.7 years to 11.6 years for men and by 1.3 years to 13.2 years for women, the expected time lived in poor health from age 65 onwards rose from 3.1 years to 4.3 years for men and from 5.0 years to 5.8 for women (Figure 2) [3].

Since many illnesses become more common with increasing age, these demographic changes have considerable implications for health care. An ageing population brings with it a disproportionate increase in common conditions such as degenerative disorders, stroke, cancer and dementia with their attendant disabilities[4]. The difference between life expectancy and health expectancy is an estimate of the number of years a person can expect to live in poor health or with a limiting illness or disability. To cope with the ageing of its population Malaysia needs to develop sufficient expertise in acute Geriatric Medicine, rehabilitation of older people; the management of long-term conditions in older people with multiple complex problems within Primary Care; as well as an infrastructure for home and institutional care. There is an urgent need to train physicians, nurses, allied health professionals, and care home workers to enable them to deliver a safe and effective system of health and social care for older people. Whilst public health measures may extend life expectancy further they will do so at the relative expense of increased prevalence of currently incurable conditions such as dementia and Parkinson's disease[4, 5].

A system that cares for older people

A healthcare system focussed on acute medical care will be ill prepared to address the task of caring for older people, which requires a whole system approach. The Malaysian Government has been proactive in their approach to these demographic changes. In 1995, following a conference on the health care needs of older people, a series of short and medium term goals were set. Non-governmental organisations, notably the National Council of Senior Citizens Organisations of Malaysia (NACSCOM), the Gerontological Association of Malaysia (GEM) and others have provided further impetus to developing policies and services related to elderly issues. Current policy anticipates that every state will have a Geriatric unit by 2005. This noble objective has not yet been achieved.

With the exception of paediatricians and obstetricians, all doctors will need to care for older people and so their training should provide them with exposure to experts in Geriatric Medicine. With an increasing proportion of the population being elderly, no matter how well they age, the absolute numbers of those with complex medical problems will also increase. In England and Wales this means that 40% of the NHS and 50% of Social Services budgets are consumed by older people's services[6]. These facts alone should render redundant any debate as to whether Malaysia needs to develop the specialty of Geriatric Medicine and justify the

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Table I: Patient visits by age group and sex to the Family Practice Clinic at University Hospital, Kuala Lumpur.[7]

	Male	Female	Total
< 50 years	30.2%	30.7%	30.4%
51 - 60 years	24.1%	26.1%	25.3%
> 60 years	45.7%	43.2%	44.3%

Table II: Prevalence of psychiatric illness in older people in general hospitals vs. community vs. care homes in the UK.[14]

Diagnosis	Community Prevalence	Hospital Prevalence	Care Home Prevalence
Depression	12%	29%	30-50%
Delirium	Not known	20%	Not known
Dementia	5%	31%	32%
Anxiety	3%	8%	Not known
Schizophrenia	0.5%	0.4%	Not known
Alcoholism	2%	3%	Not known

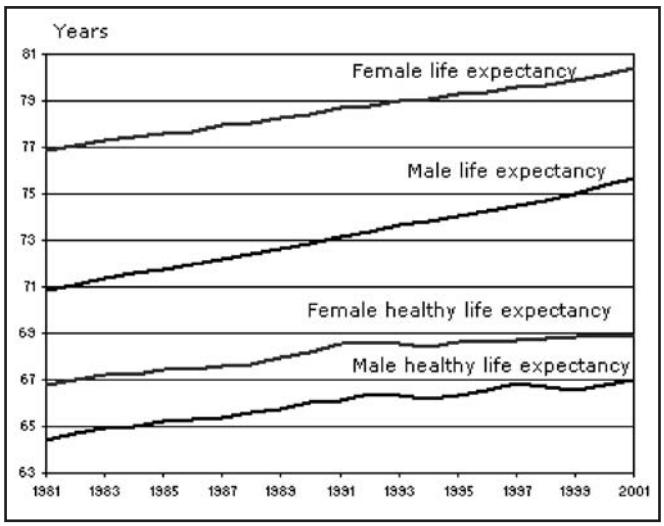

Fig. 1: Life expectancy and healthy life expectancy at birth: by sex in UK.[3]

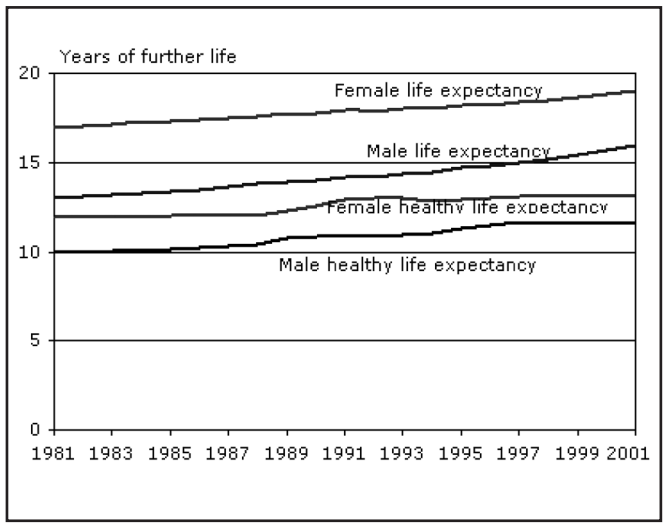

Fig. 2: Life expectancy and healthy life expectancy at age 65: by sex in UK.[3]

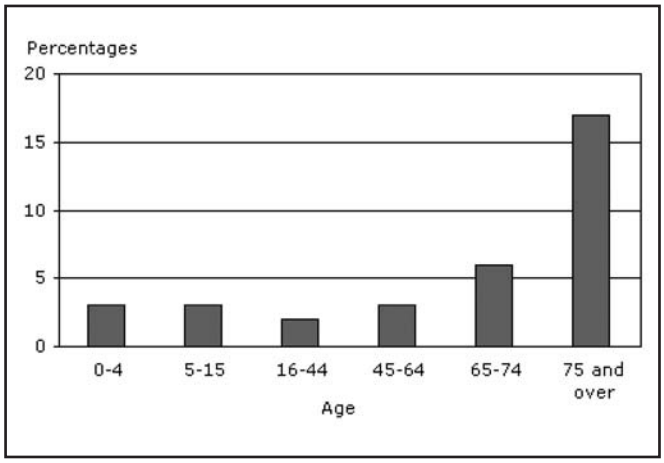

Fig. 3: Percentage of NHS GP consultations taking place at home: by age, 2002/03, UK.[3]

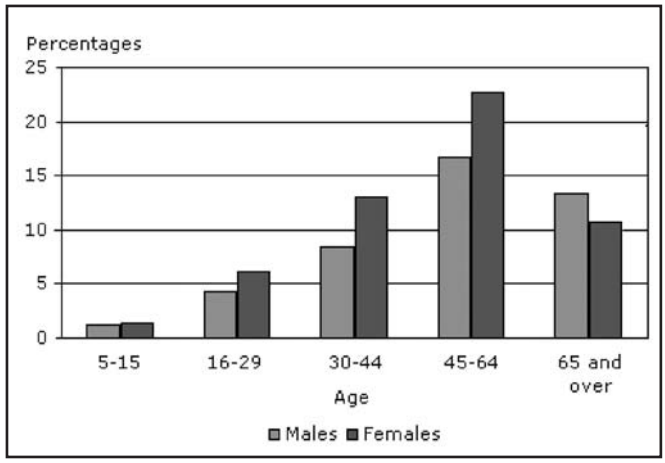

Fig. 4: Carers: by age and sex, April 2001, England & Wales.[17]

importance of the specialty to both health and social care systems.

As Malaysia ages older people will be responsible for an increasing percentage of general practice consultations and acute hospital admissions (Table I)[7]. In Malaysia older people make an average of six consultations per year as compared to the national average of 2.3 visits per year for younger people[7]. In the UK, the general practitioner will take into account factors such as the severity and urgency of the condition, as well as the patient's access to transport, distance from the practice and their ability to communicate over the phone

before deciding whether to visit the patient at home or not (Figure 3)[3]. Where older people are more vulnerable to illness, are less likely to own a car, may be less willing or able to use a phone and are more likely to be housebound than younger age groups then the need for domiciliary care will rise. In the UK 35.8% of hospital activity is consumed by people over the age of 65 years[8].

Thus, Geriatric Medicine needs to be firmly embedded in undergraduate and postgraduate curricula (medical, nursing, and allied health professionals) so that current and future generations of health care professionals develop skills to assess and manage the older patient. The strengths of comprehensive geriatric assessment [9,10] need to be emphasised in any education programme, emphasising the importance both of the assessment of complex and often multiple problems in older people as well as the long-term management of chronic diseases. An understanding of the usual trajectory of common diseases, can facilitate sensible and sustainable chronic care management programmes (which can incorporate care pathways), hopefully to maintain older people in a community setting, avoiding unnecessary hospital admissions. For this to happen, there will need to be an expansion of the present number of geriatricians (eleven in the entire country and mostly based in Kuala Lumpur) and equitable deployment based on demographic patterns within East and West Malaysia. Experience in Western health economies is that the unpredictable timescales involved in health care management of older people (i.e. it is generally easier to predict length of stay for elective surgical and medical interventions than for acute care and rehabilitation of older people) often excludes them from private health care, whether insured or self-funding. Given the current structure of the Malaysian health economy, incentives may be required to recruit and retain health care staff trained in older people's services, in particular to ensure that newly trained geriatricians do not opt to enter a variety of private practice settings and not return to the medical schools to train others [11].

Geriatric medicine should be well integrated into the undergraduate curriculum at all stages. Medical students need to be taught to develop the ability to assess and manage the elderly patient, and to recognise atypical presentations of common diseases in this age group[12]. At a postgraduate level the medical problems of older people need to be championed as interesting, challenging, and treatable. Enthusiasts in the field need to promote the training programmes offered by the Ministry of Health as well as providing leadership and vision in developing services and training. This burden of work will get easier as the specialty numbers increase. Traditional barriers between the roles of nursing, allied health professionals and medical staff need to be challenged and removed. Likewise links between primary and secondary care need to be strengthened if Malaysia is to provide a seamless service for older people.

The main burden of health care for older people will lie within primary care. Appropriate and thorough assessment of older people takes time, which will need to be allocated accordingly. Thus it is important that all doctors entering into primary care receive formal training in Geriatric Medicine. Failure to integrate the care of older people into primary care programmes will lead to an excessive burden of care falling onto hospital services, with acute beds becoming overwhelmed. Older people with complex needs require access to specialist geriatric services in a wide range of care settings not just in acute hospitals. Just as the UK and Australia are developing alternatives models of care in an effort to reduce hospitalisation rates of older people, so Malaysia too will need to consider establishing community teams comprising geriatricians, specialist nurses and general practitioners with a special interest in older people (GPwSIOP)[13]. This will not be easy to achieve whilst Malaysians are not registered with a general practitioner and doctor shopping is a cultural norm.

Malaysia is blessed with an excellent system of maternal and child health surveillance. With proper training, these health care workers could easily provide the foundation for older people's health services in a community setting: implementing physical and mental health screening (with tools validated in the major ethnic groups) and surveillance programmes. In the first instance this could be as simple as monitoring blood pressure, screening for diabetes, dementia, depression and anaemia. Inevitably this will require a shift in culture for this group of workers and an ability to manage change. Positive attitudes, absence of stereotyping and providing better learning experiences in nursing educational programmes will benefit older people who seek health care and provides a positive challenge for schools of nursing to develop a module of geriatric nursing to satisfy that will enable nurses to provide a high standard of care for older people.

In both community and hospital settings older people have a high prevalence of mental health problems such as delirium, dementia and depression [Table II] [14]. Malaysia will also need to strengthen its diagnostic, treatment and support services for older people with mental health problems. This will necessitate training of old age psychiatrists; specialist nurses in old age psychiatry; as well as adequate training and support of general practitioners to enable them to recognise and manage mental health problems in older age. It will be necessary to develop community support for families of dementia sufferers: respite care programmes; home care; and skilled care home facilities. The latter being particularly important as dementia and the behavioural and psychiatric symptoms of dementia are the commonest reasons for institutionalisation. Issues pertaining to community support for carers are generic and not confined to those with mental health problems.

As a consequence of the falling birth rate in Malaysia, 33.3% of the Malaysian population were below age 15 years in 2,000 compared to 36.7% in 1991 (crude birth rate of 31 per 1,000 in 1987 vs. 24.5 per 1,000 in 2,000), [1,15,16] the burden of care will increasingly fall on older people. In 2001, 17% of over 65s in England and Wales cared for someone-else (Figure 4); one third did so for more than 50 hours per week[17].

Developing services for older people will be meaningless if they are not culturally acceptable. It will be essential to educate the public, health professionals and commissioners

of services as to the potential benefits of rehabilitation and focussed services for older people[16]. The ability of older people, even those with dementia, to make functional recovery from a severe illness will need to be promulgated to overcome any tendency that the older person and their family may have to foster an unnecessary state of dependency. This will require a programme of education and support for families, involving them in structured rehabilitation programmes rather than simply providing informal care in the way they think fit. Specialist nurses and geriatricians will need to develop links with other hospital specialists, especially orthopaedics, to ensure that elderly patients in every hospital service are appropriately assessed, diagnosed and rehabilitated. This will ensure that only those who need to be are discharged to care homes. The result will be reduced levels of dependency in the population, reduced health and social care costs (to the nation or the individual) and fewer relatives needing to adopt the role of carer.

The increasing acceptability of long-term institutional care in Malaysia should drive the development of care home medical services. Dementia is the commonest diagnosis in care homes; care home residents also tend to have multiple complex medical problems which will, at different times, be active. Specialist services for older people need to be available to those living in care homes as much as those living in their own homes. Specialist nurses or GPwSIOP could provide the foundations of this care home medicine, with support for education, audit, clinical governance and research coming from departments of Geriatric Medicine[13].

CONCLUSION

There is enthusiasm for developing Geriatric services in Malaysia at all levels from the Ministry of Health down. However, the plan to develop a geriatric unit in each of 14 states by 2005 was over optimistic, as Malaysia does not yet have the skills to staff such units. Setting up geriatric units without training individuals in Geriatric Medicine is likely to result in staff becoming demoralized and even more likely to leave. Standards of care will fall and give Geriatric Medicine and these units a poor reputation, making it even harder to recruit and retain staff. Whilst the time-scale was unrealistic, something does need to be done, so Malaysia must look for enthusiasts, nurture and develop them. The University of Malaya should be encouraged to develop a Fellowship or Masters programme for those wishing to specialize in Secondary Care Geriatric medicine. Influencing governmental policy would be so much easier if there were a champion for older people within the Ministry of Health to help direct developments and ensure that Malaysia learns from the developed countries rather than simply copying them.

The differential earning potential between government and private sector undermines the ability of governmental hospitals to retain staff. Although sponsorship is on offer for training in Geriatric Medicine, and countries such as Australia and the UK can offer attractive opportunities for training and research, being bonded to the government and a poor earning potential are significant disincentives. Services for older people are not just about doctors. Malaysia must also provide adequate training opportunities and incentives to nurses and allied health professionals. Age should not be a barrier to staff training, for those who declare an interest in the field are likely to become champions for Geriatric Medicine and attract others in to the specialty.

The Masters in Family Medicine at University of Malaya in Kuala Lumpur includes Geriatric Medicine – this should be used as a model for training primary care and setting the foundation of geriatric care outside hospital, close to home. Although primary care could be the cornerstone of care for older people, there is a problem of using this model in Malaysia: (a) GPs are mostly in private practice and may find complex geriatric assessments financially unattractive; (b) doctor shopping and lack of named GP lead to (c) poor communications between primary and secondary care. Thus there are significant obstacles to developing a seamless health service. Nonetheless, this is a model worthy of consideration rather than following the historical root of the UK in developing a secondary care geriatric service only later (20th-21st Century) realizing the necessity to develop community geriatric services.

The legacy of Derek Llewellyn-Jones is an excellent infrastructure to health care in the Kampongs. The current service could provide an excellent foundation upon which to build older people's services. But this also requires a belief in the importance of developing community geriatric services. The nurses in the health clinics should provide elderly care as well as child and maternal care. This needs to be introduced sensitively so that staff do not feel overwhelmed. It could be easily done and should start with simple screening – blood pressure, anaemia, diabetes, mobility problems – no more than the nurses currently do for maternal and child health. This would not over burden the primary care doctors as the nurses would be paid to do this and would only pass on those with identified problems.

Enthusiasm to implement further screening of older people needs to be tempered. Screening needs to be for problems that the health system can cope with, not to identify unmet and unmeetable need. As screening tools are developed and implemented they need to be socio-culturally sensitive not just adopted from the West. For example, the Paired Associations Learning Test (PALT) can differentiate Alzheimer's from depression and non-demented and may also differentiate dementia with Lewy bodies[18]. It is language independent and can be used on a PDA. In remote areas, where literacy and numeracy may be an issue, PALT may be a more appropriate tool than the more commonly used Folstein Mini Mental State Examination (MMSE). The important point is to use a tool that is validated for the population being studied and that the investigator is familiar with.

Any new developments need to be thought through before being implemented and then rigorously evaluated. Policy makers will be well advised to remember that they are developing a system that they may need to depend upon in the near future. Providing an answer to all the challenges should incorporate the best aspects of the many models of healthcare delivery in the developed world. To use a "one model fits all approach" (i.e. whatever suits the West would also suit Malaysia) will be neither practical nor sensible.

Malaysia needs to swiftly develop systems to cope with its increasing numbers of older people, whilst recognising any ethnogenic factors that will influence future health and social care needs (e.g. high prevalence of hypertension and diabetes; and falling birth rates). Other sociological factors also need to be considered, e.g. will today's house-maids in the future provide disability care and how might they be trained to do so?

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