Ageing and mental health resources for older persons in the WHO South East Asia Region

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Abstract

The World Health Organization (WHO) South East Asia Region is the smallest region among the 6 WHO world regions in number of countries but it contributes to 28% of its population. The demographic transition (from a high child mortality and a low life expectancy to a low child mortality and a high life expectancy) is happening in a high speed: the region has 20% of the world elderly population, which places it at the third place as the oldest region in the world. Consequently, there is a high risk of an increasing number of older persons with mental disorders. To better understand the organization of care for older persons, data is being collected to reduce the imbalance between ‘disease information’ and ‘resource information’ – information which addresses the older persons’ needs in terms of mental health care. This article presents some results for this region. Because mental health problems among older adults are still not a public health priority, the careful examination of each country nevertheless reveals certain specificities, such as divergent life expectancy or different values regarding aging. The authors present some recommendations for the development of care for old persons with mental disorders in this region based on the general recommendations made by WHO in the World Health Report 2001 (WHR 2001) and by WHO and the World Psychiatric Association in some consensus statements on Psychiatry of the Elderly.
Introduction

The current demographic transition, which shows the population of several countries rapidly ageing, is leading to an increasing number of older persons with mental disorders. These disorders account for a substantial proportion of disease disability and burden, but current resources for mental health in this specific age group are very often inadequate. The quality and quantity of mental health resources need to be improved to meet current and future needs. Accurate information on existing resources is part of the process of improving mental health in old age.

To better understand the organization of care for older persons, data is being collected in the context of the project Atlas (de Mendonça Lima CA, 2004). The goal of this project is to reduce the imbalance between ‘disease information’ and ‘resource information,’ which is a significant impediment for planning mental health services, in particular those for older persons (defined as those persons aged 60 or more). A lack of information on resources also hampers efforts made by non-governmental organizations, professional associations and consumer groups to demand the improvement of mental health care services and to highlight any needs specific to older persons.

The present article presents some results for the WHO region of the South East Asia Region (SEAR). The methodology of the project has been described elsewhere (de Mendonça Lima CA et al. 2004) and some preliminary results were already published (de Mendonça Lima CA et al. 2004, de Mendonça Lima CA et al. 2005, de Mendonça Lima CA et al. 2007).

Results

The following data by country are already available:

- Demographic distribution: total and over 60 years;
- Life expectancy at birth;
- Total expenditure on health as a percentage of the Gross Domestic Product (GDP) and the per capita total expenditure on health at the official exchange rate (both for 2002);
- Identification of the NGOs in each country working in the field of mental disorders in old age (psychiatry, neurology, geriatrics/gerontology, and consumers of health services).

The three first groups of data were essentially collected from the World Health Report 2005 (World Health Organization, 2005). The data concerning the NGOs was obtained at the websites of the World Psychiatric Association (http://www.wpanet.org/), the World Federation of Neurology (http://www.wfneurology.org/), the International Association of Gerontology and Geriatrics (http://www.iagg.com.br/) and the Alzheimer’s Disease International (http://www.alz.co.uk/).

Ten countries are part of SEAR. Some particularities of this region influencing the population growth are:

- The high global density of the population: 28% of the world population living in the smallest WHO region where part of the territory is quite impossible to live (Himalaya Mountains, insularity, etc.). This contributes to difficult changes and transportation;
- The almost simultaneously (and conflictive) co-existence of three different cultures – Islamic, Buddhist, Hinduism – with its particular traditions in terms of marital status, reproduction and value of the old age;
- The presence of important international conflicts these last 50 years which are in the origin of important migration of people;
- The socio-economics conditions characterized by important global poverty of population.
In 2003, SEAR had 1,613,867,000 inhabitants with approximately 123,245,000 inhabitants aged 60 or more (7.6% of the total population). While the total population of this region represented approximately 28% of the total world population, the persons aged 60 or more represented 20% of the total old population (Figure 1).

According to Table 1, the three biggest countries in the SEAR region, in terms of population, were India (1,065,462,000 inhabitants), Indonesia (219,883,000 inhabitants) and Bangladesh (146,736,000 inhabitants): together these countries had 88.7% of the total population and 87.8% of the total old population of SEAR. The countries with the highest proportion of old persons were also India (67.4% of total region old population), Indonesia (14.3%) and Bangladesh (6.1%).

The mean life expectancy at birth in 2003 for the entire region was 63.1 years, but there was a significant variation of this parameter among the countries, with the life expectancy at birth ranging from 59 years in Myanmar to 71 years in Sri Lanka. The life expectancy at birth in this region was quite the same for women and men in almost all countries of the region. In other regions of the world women have a longest life expectancy at birth. This result suggests that probably women in SEAR’s countries face to health problems that in other regions of the world doesn’t have the same impact for them in terms of mortality.

An important factor contributing to the life expectancy at birth is the country’s development level. It can influence how countries spend financial resources on health. We may consider how much money is available for the health system: this can be measured by the per capita total expenditure on health at the official exchange rate. The mean for the region in 2002 was US$ 37.10. Myanmar had the highest expenditure in the region: US$ 315. This country was followed by Maldives (US$ 120) and Thailand (US$ 90). Nevertheless, this classification doesn’t correspond to these countries life expectancy at birth: they have to pursuit this financial effort for a longer time before collecting enough positive results in terms of mortality rate reduction.

We also have to consider how much of the available financial resources are allocated for health by authorities. This can be measured by the total expenditure on health as a percentage of the Global Domestic Product (GDP). The mean for the region was 4.6%, with India (6.1%), Maldives (5.8%) and the Democratic People’s Republic of Korea (4.6%) investing the most in health in 2002.

A preliminary survey using data from the websites of the World Psychiatric Association (http://www.wpanet.org/), the Alzheimer’s Disease International (ADI) (http://www.alz.co.uk/), the International Association of Gerontology and Geriatrics (http://www.iagg.com.br/), the World Federa-
tion of Neurology (http://www.wfneurology.org/) and the answers to a questionnaire send by authors to all these associations, helped us to conclude that:

- 6 countries had at least one national association of psychiatry;
- only 2 countries (India and Indonesia) had an organization or a section of the national association of psychiatry addressing psychiatry for the elderly;
- although ADI is not an association which covers all mental health needs of older persons, it is nevertheless a federation of national associations for persons with Alzheimer’s disease and their caregivers. There was a national organization with membership in ADI in 4 countries;
- very often, the mental disorders of older persons are addressed by geriatricians and/or neurologists. There are in the region 4 national associations of geriatricians and 6 national associations of neurologists.

Tab 1. SEAR countries and their respective total population, percentage of persons with over 60 years old, total expenditure on health as a percentage of country Global Domestic Product (GDP), per capita total expenditure on health (US $), life expectancy at birth and presence of a national association of psychiatry, psychiatry of the elderly, geriatrics/gerontology, neurology and Alzheimer’s disease.

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<td>6.5</td>
<td>4.5</td>
<td>12</td>
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<td>4.6</td>
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<tr>
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<td>6.1</td>
<td>30</td>
<td>62</td>
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<tr>
<td>Myanmar</td>
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<td>315</td>
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<tr>
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* in thousands n/a: not available
As a result, we can say that 70% of the SEAR countries had at least one association that addresses some elements of mental health in old age. This good result is quite surprising because the region has a relatively low proportion of elderly people and a low life expectancy at birth when compared to other regions in the world. This could be explained by (i) cultural and religious values towards old people, (ii) public sensitivity to ageing and (iii) the conscious of the consequences in terms of population’s health for the next few years when the number of old people will significantly increase.

The role that NGOs may have in the promotion of good care for people was strengthened by the WHO at the WHR 2001 (World Health Organization, 2001): NGOs are more sensitive to local realities and are strongly committed to innovation and change. The report recognized that International NGOs foster exchange and function as pressure groups, while National NGOs are responsible for innovative programs and solutions at the local level.

Discussion

The World Health Organization and the World Psychiatry Association defined psychiatry of the elderly as a branch of psychiatry that addresses concerns related to the psychiatry of people of ‘retirement’ age and beyond (65 years, in general, but some countries and local practices may vary) (World Health Organization & World Psychiatric Association, 1996).

In this context, what should be the place of the psychiatry of the elderly in SEAR, a region where the proportion of persons with more than 60 years is around 7.6%, and the life expectancy at birth is lower than 65 years in 50% of countries? This may not justify the development of specific policies, programs and services for this population. But surely this does not imply that the health authorities of the countries of the region should neglect care for older persons, in particular mental health care. This is mainly justified but the high speed of the present ageing process which will provoke in the next few years a significant increase of the old population.

Thus, we adapted the WHO general recommendations presented at the WHR 2001 (World Health Organization, 2001) and at the WHO/WPA consensus statements of Psychiatry of the Elderly (World Health Organization & World Psychiatric Association, 1996 e World Health Organization & World Psychiatric Association, 1997) and propose the following measures to promote the mental health of old persons in the region:

Minimum actions required for mental health care for old persons

1. Provide treatment in primary care
   - Recognize mental health of old persons as a component of primary care.
   - Include the recognition and treatment of common mental disorders in old age in training curricula of all health personnel.
   - Provide refresher training to primary care physicians in contact with old persons.
   - Develop locally relevant and adapted training materials in Psychiatry of the Elderly
2. Make psychotropic drugs available
   - Ensure availability of all essential psychotropic drugs to old persons in all health care settings.
   - Develop basic educational and training interventions for caregivers.
3. Give care in the community
   - Deliver mental health care for older people in the community by personnel specifically trained and working in adapted structures.
   - Refer patients to an old age psychiatry service when further opinion and advice are needed and/or for direct specialist care. At least one kind of this service should exist in each country where the proportion of old people in the population becomes significant.
- Develop mental health care services to ensure the promotion and the prevention of mental health and early identification of mental disorders in old age. These services should include the assessment, diagnosis and multidisciplinary management of care to people with all kind of mental disorders in old age.
- Organize services of care in such a way that they are readily available and accessible to individual patients together with their families and caregivers. These services should be flexibly interlocking, overlapping and integrated to provide a unified system for continuing care and best possible quality of life.
- Move old people with mental disorders out of inappropriate institutional settings.

4. Educate the public
- Include in public campaigns against stigma and discrimination specific topics concerning old people.
- Support nongovernmental organizations in public education on specific topics concerning old people.

5. Involve communities, families and consumers
- Promote the formation of self-help groups to support individual patients, together with families and caregivers.
- Fund schemes for nongovernmental organizations and mental health initiatives in the field of Psychiatry of the Elderly.

6. Establish national policies, programmes and legislation
- Revise legislation based on current knowledge on human rights considerations concerning old people.
- Ensure that the mental health programmes and policies sufficiently take into account the mental health needs of old people.
- Ensure that the budget for mental health care is sufficient to cover the mental health needs of old people.

7. Develop human resources
- Train primary health care workers in Psychiatry of the Elderly.
- Ensure that specific topics of Psychiatry of the Elderly are present at the graduation and post-graduation courses of all health professionals involved in the care of old persons.
- Develop training and resource centers.

8. Link with other sectors
- Develop programmes to prepare people for retirement.
- Ensure that justice appropriately responds to the needs and rights of old persons.
- Develop support for nongovernmental organizations related to Psychiatry of the Elderly

9. Monitor community mental health
- Include mental disorders in the elderly in basic health information systems.
- Survey the specific group of old persons.

10. Support more research
- Conduct studies in primary health care settings on the prevalence, course, outcome and impact of mental disorders in old people living in the community.

Conclusion

SEAR still have a low proportion of older persons in their population but it is estimated that the number of old people will increase significantly in the next years. Strong cultural forces affect the growing and ageing processes, and some international conflicts are causing premature deaths and migration.
Some countries’ population is still affected by epidemic and endemic communicable disorders. Poverty, with all the consequences it may have for health, is possibly the most important factor negatively influencing people’s quality of life and life expectancy at birth.

Mental health for all ages should become a priority issue in the public agenda in the region. However, it is also important to offer already opportunities of good care to the existing older populations. At the same time it is important to be flexible enough to adapt a system of care which reflects the specific local needs of each country.

The effort of the national governments to promote mental health should be made in respect of the principles of organization of care for old persons with mental disorders (World Health Organization & World Psychiatric Association, 1997), adapted to local resources and cultures. As mental disorders in old age can represent a severe limitation for older persons and their families to live with a good quality of life, care should be extended to all concerned. The challenge of finding solutions for better living conditions of older people with mental health problems lies in the hands of researchers, policy makers and the population. Funding and creativity are two factors necessary to find solutions.
References


