

# Ageing: The Response Yesterday, Today and Tomorrow

D Eldemire-Shearer

## ABSTRACT

*This is an overview of the phenomenon of population ageing and ageing trends in Jamaica. It documents landmark policy achievements and responses to population ageing and analyses related social, economic and health implications, as well as, the challenges and opportunities of ageing. The interdigitations of ageing issues and public health is manifest from the early historical milestones in ageing research to the establishment of the Mona Ageing and Wellness Centre to the continuing collaborative work with international agencies such as the World Health Organization (WHO).*

*The contribution of the University of the West Indies (UWI) through the Department of Community Health and Psychiatry to ageing research and policy is documented.*

## El Envejecimiento: la Respuesta Ayer, Hoy y Mañana

D Eldemire-Shearer

## RESUMEN

*Este trabajo ofrece un panorama del fenómeno del envejecimiento de la población, y las tendencias del envejecimiento en Jamaica. El mismo documenta los logros más sobresalientes en cuanto a las políticas, así como las respuestas al envejecimiento de la población. Asimismo, analiza las implicaciones sociales y económicas relacionadas, las implicaciones para la salud, así como los retos y oportunidades del envejecimiento. Los entrelazamientos de los problemas de envejecimiento y la salud pública se han puesto de manifiesto desde los hitos históricos tempranos en la investigación sobre envejecimiento, hasta la creación de Centro de Bienestar y Envejecimiento de Mona para el trabajo de colaboración continuo con agencias internacionales tales como la Organización Mundial de la Salud (OMS). Se documenta la contribución de la Universidad de West Indies (UWI) a través del Departamento de Salud Comunitaria y Psiquiatría a las políticas e investigaciones de envejecimiento.*

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## INTRODUCTION

Population ageing, the process by which older individuals become a proportionally larger share of the population is a demographic phenomenon resulting in more older persons (1). Referred to as the demographic transition, it is the period of transition from high to low birth and death rates (2) [Fig. 1]. Population ageing is one of the most significant demographic events of the twentieth century.

Old persons have been defined as persons sixty years and over (3). The process (that is population ageing) initially

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From: Department of Community Health and Psychiatry, The University of the West Indies, Kingston 7, Jamaica, West Indies.

This was delivered by Professor D Eldemire-Shearer at her inaugural professorial lecture on the sixtieth anniversary of The University of the West Indies.

Correspondence: Professor D Eldemire-Shearer, Department of Community Health and Psychiatry, The University of the West Indies, Kingston 7, Jamaica, West Indies. E-mail: denise.eldemireshearer@uwimona.edu.jm

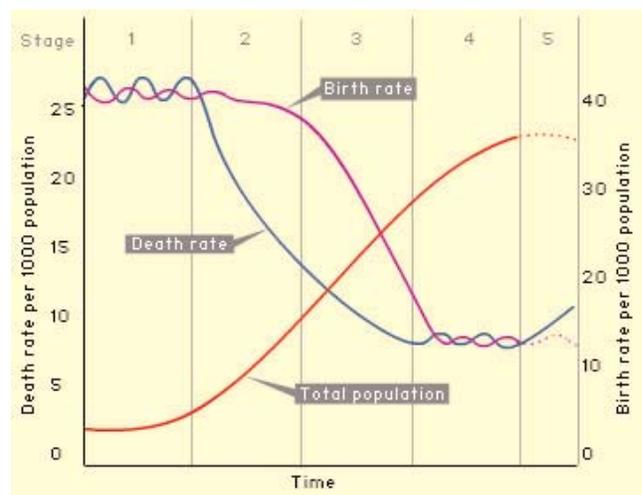


Fig. 1: Demographic transition

Source: Wikipedia, the free encyclopedia. (2008)

manifested in developed countries by the 1950s in recent times has become a feature of developing countries. The fifty-year gap (1950 to 2000) between the processes in the two has meant that although population ageing is a worldwide phenomenon, the circumstances in which countries experience ageing are very different.

Population ageing in the developing world is occurring at unprecedented rates in countries with lower socio-economic development and therefore lower Gross Domestic Products (GDPs). These countries are also experiencing rapid rates of globalization, industrialization, urbanization and technology development, unlike the economic boom of the 1950s when the developed countries aged and had money to develop institutional care.

In addition, the pattern of diseases is changing as the epidemiologic transition *ie* the shift from infectious to chronic diseases as major causes of deaths, is taking place. Yet, at the same time, developing countries are facing major problems with HIV/AIDS and some re-emerging infections for *eg* tuberculosis (TB).

In 1950, the older population of the world's people was 8%; 11.7% in developed countries and 6% in developing countries. By 2000, it had increased to 10%; 20% in developed and 8% in developing countries. It is projected to grow to 21% in 2050 over a 100% increase [33% in developed, 20% in developing countries] (1).

Most importantly, the population ageing impacts profoundly on almost all aspects of life, especially economic, financial and social, including health. The demographic changes that began in the mid 20<sup>th</sup> century will continue well into this century. The reversal in the proportions of the young and old age groups will continue. Population ageing is presenting countries with challenges. Developing countries cannot copy and adopt the responses of the developed world but will have to fashion their own responses, unique to their existing socio-economic circumstances and resources.

**JAMAICA**

The Caribbean has been identified as having the fastest growing ageing population (4). While not having the numbers of the larger developing countries such as China and India, it is a challenging issue relative to the size of its economies (Table 1).

Table 1: Ageing in the Caribbean (thousands)

Age	Year			
	1975	2000	2025	2050
60+	2192.2	3748.3	7478.9	11780.4
80+	190.2	539.2	1074.7	2431.2
100+	N/A	1.6	5.2	16.0

Source: UN 2002

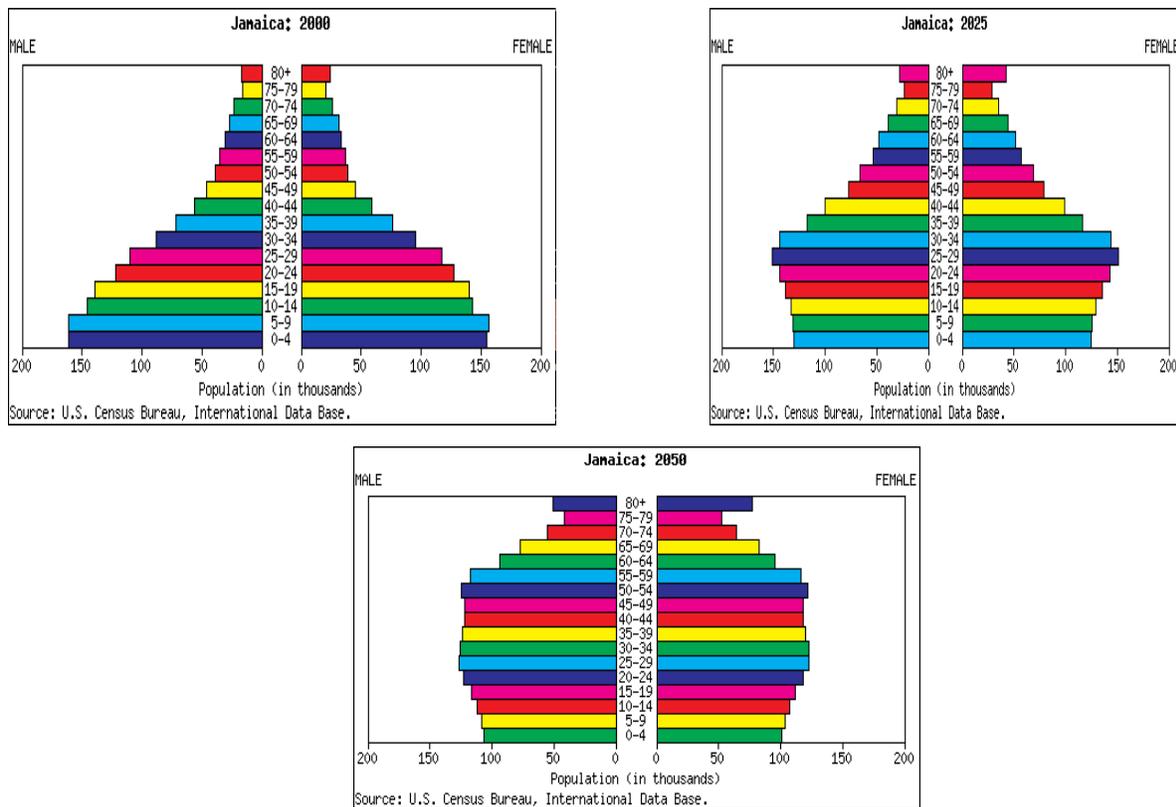


Fig. 2: Jamaica – the demographic transition

Source: Census Bureau, International Data Base

The Jamaican population is experiencing the demographic transition as seen in the three population pyramids (5) [Fig. 2]. Since 2000, this fact has also been noted in the official publications of the Planning Institute of Jamaica [PIOJ] (6). The ageing of the population became discernible after the 1960s when research began to highlight the issue. The over sixty population grew from 6.7% in 1960 to 10.2% in 2001.

While the percentage growth may not seem substantial, it represents over a 100% increase in numbers 108 000 to 264 772 (6). For the period 2000 to 2005, the population of 60 years grew at 1.5% while the total population grew 0.9% (1). The over 60 years population will double during the period 2025 – 2030 while total population growth continues to fall. An important feature of the demographic transition is the period in which the young population has fallen below 30%, the adult population 15 – 59 years has increased but the sixty plus has not significantly increased yet, that is not above 15%. Referred to as the window of opportunity or the demographic dividend, the increased numbers in the working age in economies which provide employment can boost economic growth, savings and investment (2). For Jamaica, it is the period 1980 – 2025. It also allows for putting policies and programmes in place for the increased numbers of older persons (1).

Both the magnitude and speed of population ageing is significant (Fig. 3). The growth of the 60+ population is even

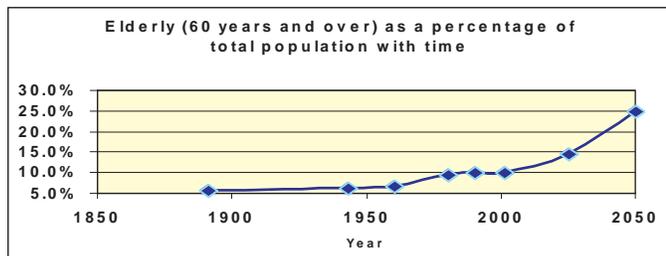


Fig. 3: Growth of elderly population

Source: Eldemire-Shearer 1998

more significant when compared to the situation of other age groups (Table 2). Between the years 1970 – 1980, the

Table 2: Jamaican population – The statistics

Age distribution	1975	2000	2025	2050
0 – 14	45.2	31.5	23.0	19.3
15 – 59	46.3	58.9	62.6	56.7
60+	8.5	9.6	14.5	24.0

Source: UN 2002

population of 60+ years increased by 26.8%, the total population by 13.6% and the under five years decreased by 11% and the trend has not changed.

The changes in the age groups are reflected in the changes in the overall dependency ratio. The child dependency ratio has fallen from 90 per 100 in 1970 to 57.2 per 100 in 2001 while the old age dependency ratio has risen 10.8 per 100 in 1970 to 16.1 in 2001 (Table 3). The age

Table 3: Dependency rates 1975 – 2025

	Total	Old Age	Youth
1975	104.2	11.8	92.4
2000	63.1	11.8	51.3
2025	49.0	14.8	34.2

distribution changes will accelerate over the next 50 years and have an impact on the development and delivery of services.

The changing age distribution is also reflected in the increasing median age of the population, 24.2 in 2000 to 39.0 in 2050 which will have an impact on the labour market and labour policies.

The ageing of the population is described in several ways: increases in life expectancy, increases in numbers of the 60+ in relation to other age groups, increases in the old (80+ years) and the gender ratio (that is feminization). Each has its own implications for policy and programme development and implementation.

## LIFE EXPECTANCY

The older population is itself ageing and life expectancy has increased from the mid-fifties in 1950 to mid-seventies in 2005 (Table 4). There are gender differences as females have

Table 4: Life Expectancy 1950 – 2025

Life Expectancy in Jamaica:			
By Gender			
	1950	2000	2025
Male	56.9	73.7	76.8
Female	60.2	77.8	81.2
By Age Group			
	2000 – 2005	2025 – 2030	
Total	75.7	79.0	
60 Years	21.3	22.9	
80 Years	8.3	9.1	

a 3 – 4-year advantage over men. Increasingly, life expectancy at different ages is being used to describe the population. With the increase in life after 60 years, the elderly has been divided into young old (60 – 80 years) and old [80+ years] (7). More recently, the World Health Organization (WHO) has divided the group even further into three bands 60 – 69 years, 70 – 84 years and 85+ years. For countries like Jamaica, with competition for scarce resources, when developing social services including healthcare, a focus is placed on the group with greatest needs among the 60+ that is the 85+ years group.

As the population ages, more and more persons in their fifties and sixties will be faced with the challenges of having very old relatives to look after while having children still in college.

**NUMBERS**

The growth in numbers is important when discussing service need. Significantly, the largest increase in the 60+ population is being seen in the 80+ group [Table 5] (8–13). This group has been identified as being the most likely to have increased needs as increases in frailty, poor health status and dementia are greatest after age 80 years(12, 13). In Jamaica, there are over 46 000 persons 80+ years and many of them are in rural areas with minimal access to social services and are dependent on family and community care (Table 5).

Table 5: Over 80-year old population 1950 – 2025

Year	Totals
1975	22 000
2000	46 100
2025	68 700

The growth rate of the 80+ elderly is currently double that of the 60+ elderly (1, 6) and these growth rates are not expected to decline until after 2040 for the 60+ and 20 years later for the 80+ (Table 6).

Table 6: Population growth rates

Growth rates	1975 – 1980	2000 – 2005	2025 – 2030	2045 – 2050
Total	1.2	0.9	0.8	0.4
60+	3.0	1.2	3.2	1.9
80+	12.4	2.0	3.0	3.1

Source: UN 2002

**GENDER**

Women make up a significant majority of the older population and increasingly so with age. The needs of older persons differ according to gender, men more often having social needs, females more financial (14). Studies have also identified higher levels of poverty in older females and lower levels of literacy. This finding along with the current levels of increasing education of females emphasizes the need for cohort analysis as things will change when these more educated females become seniors.

The ageing of the Jamaica population as in most populations is characterized by a widening of the gender gap (Table 7). In 2000, at age 80, the ratio of males to females was 7:10 compared to 8.5:10 for the age group 60+ and 1:1 at birth.

This also has implications for service need and provision given the role of the female in providing care for incapacitated and/or frail relatives.

Table 7: Feminization of the older population

Sex ratios	1975	2000	2025
60+ years	85.8	84.1	80.3
80+ years	56.1	70.7	67.9

**CHARACTERISTICS**

Research has challenged the earlier picture of the older population as frail, dependent and in need. The 60+ years population has been noted to be physically and mentally well as described by functional ability (8, 9). They are however not without chronic diseases as will be discussed (11, 13, 15).

The majority live in private households (262 171), 66% being the head of the household. Only 3200 have been identified as living in institutions and approximately 10% have been identified as living alone, more males than females. Hence the family and community remain the main source of support and care when needed.

The living arrangements of the 60+ are noted as they will influence service need and provision. It is also important to note the changing nature of family dynamics. Families are smaller, females more educated, more females are in the workforce and technology; cell phone and e-mail rather than the sharing of physical space, is what keeps families “in touch”.

It is important to note that support is a two way process and older persons are also a source of support to both family and community. This was documented in one study which examined the contribution of seniors to development (16).

**OTHER IMPACTS**

The epidemiological transition has paralleled the demographic transition (Fig. 4). The morbidity/mortality

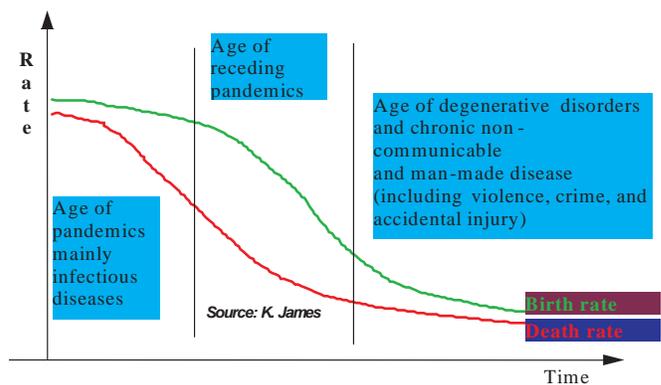


Fig. 4: The epidemiological transition

Source: Kenneth James

pattern has shifted from the main causes being infectious diseases to the chronic diseases mainly hypertension, heart disease, cerebrovascular disease, diabetes mellitus and arth-

ritis (15) [Table 8]. The five leading causes of morbidity and mortality are also referred to as lifestyle diseases and while

Table 8: Five leading causes of death, Jamaica 2002

	Number	Per 100 000
Malignant neoplasm	2686	102.3
Cerebrovascular disease	1905	71.6
Heart diseases	1774	67.6
Diabetes	1477	56.3
Assault	1045	39.8
HIV (6)	989	37.7
Hypertension (7)	784	29.9

Source: MH Vital Statistics Reports 2002

the main causes of health problem in older persons have their origins 30 to 40 years earlier in life, the impact is felt in the later years, hence the tendency to associate old age with illness. Locally, the impact of chronic disease on health status has been documented over the years by the Tropical Metabolism Research Unit [TMRI] (17, 18) and the research has been used by the Ministry of Health to design healthy lifestyle programmes for the general population beginning with school programmes (19).

### IMPACT OF CHRONIC DISEASE ACTIVITY

In recent times, 2000 onwards, there has been increasing emphasis on the need for better management of the chronic diseases nationally. No group is more affected by increases in chronic diseases than the 60+ years population. The increase in longevity means persons live longer with their disease and become more at risk of disease related complications and disability (Fig. 5). The Economic and

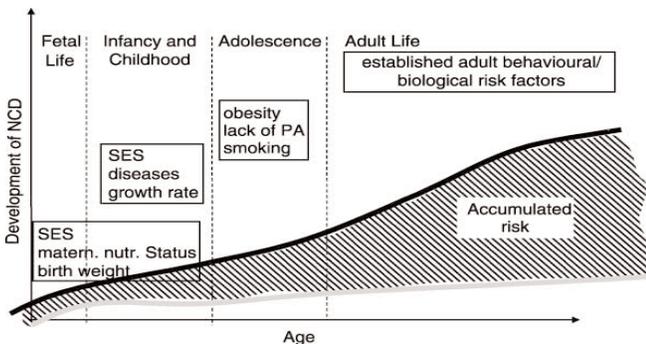


Fig. 5: A Life Course Approach to NCD Prevention

Source: Source: Aboderin *et al.*, 2002

Social Survey of Jamaica (ESSJ) 2003 reported that 37.2% and 41.1% of new hypertensives and diabetics were 60+ years and the age group accounted for over 50% of the visits to primary healthcare (PHC) curative clinics (6) and the Survey of Living Conditions (SLC) 2002 reported that 34.6% of the 60+ reported illness/injury and 62.5% of those 65+ reported having a chronic illness (20).

Even with regards to utilization of surgery services at the University Hospital of the West Indies (UHWI), the elderly are over represented. In one study, 26% of those admitted to the surgery wards were 60+ years and older and had a longer hospital stay than younger ages [11.5 days *versus* 8.0 days] (21).

### ATTITUDE

Also influencing how population ageing is seen is ageism. In the 1980s, ageism, a term defining prejudice against older persons through attitudes and behaviour, was identified as a barrier to integration (2, 22). It is particularly experienced in the labour market. Since 1999, concerns have been expressed about intergenerational warfare as age groups compete for scarce resources. It also influences how individuals see their own ageing – a good time with possibility *versus* a feared event.

### AGEING PROGRAMMES

Jamaica, even in the early 1980s, had a well established Government programme on ageing matters. In 1976, The National Council on Ageing (now called The National Council for Senior Citizens) was established in the Ministry of Community Development but now is in the Ministry of Labour and Social Security.

This programme with its focus on social programmes for seniors provided those of us with an interest with an outlet for our work and the relationship between The University of the West Indies and the senior programmes began demonstrating how academia and Government could work together for mutual benefit.

In 1982, the first World Assembly on Ageing was held in Vienna and Jamaica participated (3). A paper was written focussing on the health and social aspects of ageing – this was the start of the contribution of the Department of Community Health and Psychiatry to the National Programme.

During this period (1982–1995) regional activities were also being initiated. In 1982, a five-country survey including Jamaica on the needs of the elderly was started by the Pan American Health Organization (PAHO) and completed in 1986. In 1986, PAHO Washington hosted meetings on Midlife and Older Women. Braithwaite at Cave Hill was studying the issues of elderly persons in Barbados. The regional coordinator Knox Hagley and Gerald Grell put ageing on the Health Ministers agenda. Several Governmental regional meetings were held.

In 1986, the first regional ministerial meeting on ageing was held in Colombia and again the Jamaican paper was prepared by my team. At that meeting, I established contact with the WHO's Ageing and Health Unit and what would become a lasting relationship began. That September, WHO sponsored my attendance at the London School of Tropical Medicine Course on the Epidemiology of Ageing

and the relationships started then continue today especially with Alex Kalache.

A project written as part of the course and assisted by the findings of two Master of Public Health (MPH) research studies in 1988 was funded, in 1989, by the International Development Research Centre (IDRC) and the research programme was strengthened. The project was a national survey of the 60+ population in Jamaica and formed the basis for the development of the Jamaica National Policy on Ageing. This policy was tabled in Parliament in 1997 (23).

During the visits to the London School of Hygiene and Tropical Medicine, contacts were made with Help Age International, a non-governmental organization focussing on developing countries. The result of this would be the formation of a non-governmental organization in partnership with, and housed in, the Department of Community Health with a focus on advocacy and training. The training programme began in 1992, with Help Age support, became regional in 1996 and continues today with 219 graduates.

The national survey completed in 1992 was one of few available sources of information on older persons in a developing country and led to the presentation of the findings at several UN international meetings and development of international relationships. During these meetings, the year "1999" was proposed and accepted as the International Year of Older Persons (24). This opened up many opportunities for international collaboration and further development of the research agenda.

Ageing was simultaneously being introduced into undergraduate and postgraduate training programmes, and more recently online courses. The Department of Community Health is a member of the Association for Gerontology in Higher Education (AGHE).

The year 1999 was a watershed year internationally and locally. The year celebrated as the International Year of Older Persons confirmed ageing as a developmental issue not simply a social service issue. The international celebrations with monthly activities over a 12-month period focussed attention on the issues of older persons.

In 2002, the Second World Assembly on Ageing was held in Madrid. Building on the themes of the International Year of older persons, the focus was on developing countries (25). The recommendations of that Assembly have been useful in developing the implementation plan for the National Policy as they recognize the difficulties and resource issues of countries such as Jamaica.

Locally, the advocacy work during the period 1998 to 2002 resulted in a change of approach of 'elder care' from one of dependency to one of empowerment. The United Nations (UN) principals of dignity, care, self-fulfillment, independence and participation became the focus of activities (26).

Combating ageism has been a focus of the Department of Community Health, Mona, and the National Council for Senior Citizens advocacy programme. The media has played

a critical role. There was an increase in the number of articles and pictures on positive ageing between 1980 and 1995 (16).

Much has been happening in the international arena of significance and impacting on ageing policies particularly in the field of poverty eradication. The declaration of the MDGs, while not specifically addressing ageing, are influencing social programmes and by extension older persons. The MDGs have reinforced the gender aspect of ageing increasingly being noted. Also of importance are the population related meetings which impact on population policies.

#### **ROLE OF THE UNIVERSITY OF THE WEST INDIES**

The University, in 2000, also moved to consolidate the effort which began in the 1990s. The Community Care Course having become regional, emphasized the practical aspects of University of the West Indies' (UWI) contribution. In 2000, UWI funded research on "the contribution of seniors" to development (16) and Health and Ageing became a focus in the Principals' Policy Think Tank. In 2002, a building was funded to house the ageing activities and was completed in 2005. That year the Strategic Transformation Project facilities furthered campus-related development by funding several staff members as part of the Mona Ageing and Wellness Centre. Research has continued as an important part of the centre's activities.

#### **RESEARCH**

The research work of the Department of Community Health, Mona, resulted in it being designated a WHO/PAHO Collaborating Centre on Ageing and Health in 1997. This further strengthened the research agenda which continues to highlight the healthcare and social needs of older persons (11–13). There was the WHO project on functional ageing. In 2001, another WHO multi-country study was initiated and again Jamaica was included. There were two companion studies, one quantitative, the other qualitative, "INTRA" (The Integrated Response of Countries to Rapid Ageing) and "Age-Friendly Health Centres". This time the Government partner was the Ministry of Health specifically the Family Health Unit and this relationship has strengthened. The research began by examining the response of the Primary Health Care system to population ageing. It specifically examined the factors involved positively and negatively in whether persons 60 years and over accessed primary healthcare and identified the gaps in the primary healthcare offered to older persons. It identified good levels of clinical practice but low levels of prevention [Fig. 6] (27). Healthcare workers reported asking about physical activity and diet less than 50% of the time. Seniors reported being asked even lower levels, less than 30% of the time (27). An obvious gap in health services was the reluctance of men to use healthcare services especially primary care (Table 9) and this has grown into a strong research activity of the centre. Research into one of the four geriatric giants – falls – in 2006

Table 9: Total health centre and curative visits: 1996 – 2000

Year	Total Health Centre Visits	Curative Visits		
		Total	Male	Female
1996**	1 736 253	809 824	–	–
1997	1 804 940	831 527	330 460	501 067
1998	1 887 365	899 287	358 090	541 197
1999	1 848 292	883 904	348 576	535 328
2000	1 684 222	738 711	258 607	480 104

Source: Ministry of Health, Planning and Evaluation Branch, Jamaica, 2001

\*\* data not gendered

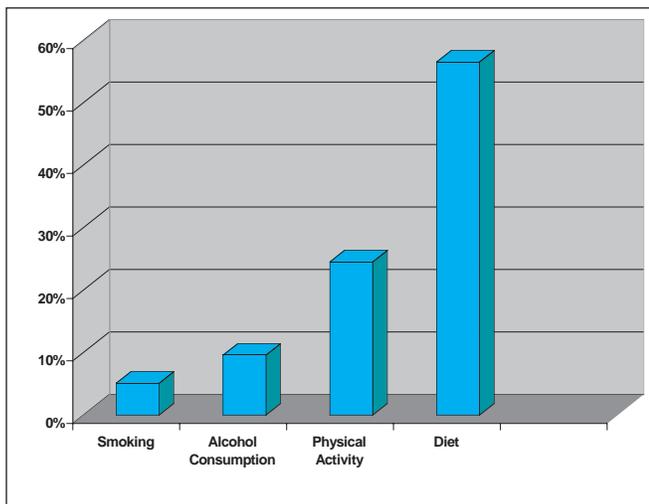


Fig. 6: Advice given by health staff as reported by patients

Source: Eldemire Shearer D, Morris C. 2002

identifying it as problem for Jamaican elderly helped draw attention to the fact that healthcare and prevention for seniors is wider than chronic disease control (28).

The primary healthcare research project is now in the second phase – the development of Age-friendly Guidelines for Health Centre Services – a joint project between the Department and the Ministry of Health – Head Office and St Catherine. The project recognizes that healthcare for older persons should include screening for problems specific to the age group and which reduce the ability to function – memory loss, depression, falls/immobility, confusion and incontinence, alongside the regular care – chronic disease prevention and management. A complementary project on Age-Friendly Cities, also a multi-country study is being done by the Centre (29).

### SUMMARY OF ISSUES AND NEEDS

Defining “the needs” of older persons has significantly changed from 25 years ago when it was “a social assistance” issue. Now “the needs” are defined by the components of

ageing which are several (Fig.7). The increasing emphasis on chronic disease management, long term care and healthcare

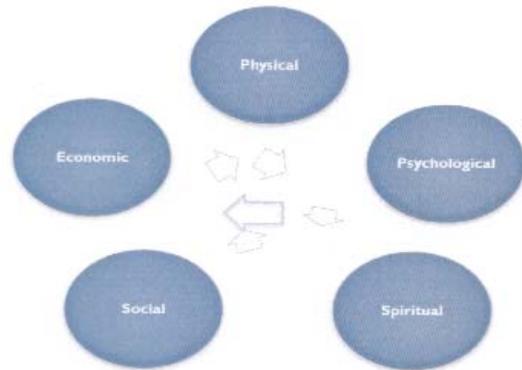


Fig. 7: Components of Ageing Process

Source: WHO/PAHO Collaborating Centre on Ageing and Health

financing and on the role individuals can and should play in managing their ageing process is also influencing policy choices. In order to identify how to go forward, a summary of the issues is useful according to the needs.

### HEALTH ISSUES

The major health needs fall into several categories including:

- C Primary Health Care issues including the need to strengthen prevention
- C Long term care issues including provision of service, financing and standards/regulating and monetary
- C Coordination of care both inter and intra-sectorally

The health status of older persons in Jamaica is characterized by chronic disease (Table 10). The morbidity and mortality according to hospital data is similar. Glaucoma and cataract have to be noted because they, along with osteoarthritis, have a major impact on a person’s ability to function.

The research findings have also highlighted the gap in available information with which to inform programme development as the studies on lifestyle risk factors only include the age group 60–74 years. Older persons of all ages need to be included in the existing research programmes to identify specific risk and associated factors so as to appropriately inform prevention programmes.

Effective clinical care depends on the early identification of illness and appropriate interventions. There is no routine screening of the geriatric giants (falls, incontinence, confusion, immobility) and this needs to be part of PHC.

The current initiative to develop age-friendly guidelines for PHC is an important start to strengthen the PHC approach.

Research has highlighted excellent clinical care but little prevention (Fig. 7). Healthcare workers reported older persons as “unwilling to change”, “stubborn” and “too old to learn” when asked to identify the barriers to prevention (27). Healthcare workers were identified as needing sensitization

Table 10: Range of community-based health related services

Home Services	Residential Services	Community Service
Emergency response system	Assisted living	Adult day care
Home-delivery meals	Continuing care retirement Community	Adult day Health Care
Home health care	Nursing home	Communal meals
Home health aide	Residential care (board and care)	Exercise programme
Homemaker/companion	Senior citizen apartments	Information and referral
Telephone reassurance /friendly visitor	Shared housing	Legal
Hospice		Money management
Home repair		Outpatient mental health Protective services Public guardian Recreation Respite care Senior centre Transportation Support group

**Source:** Modified from Damron-Rodriguez, Frank, Heck, Liu, Sragow, Cruise & Osterweil, 1998. Physician knowledge of community-based care: What's the score? *Annals of long-term Care*, 6(4), 112–121.

about ageing and the appropriate approaches and programmes for seniors especially in the area of health promotion and disease prevention (27).

The area of mental health including depression and dementia is of increasing importance given the increasing over 80 years population. There are several actions needed, including improved screening, medications, family and caregiver support. The Life-Course Approach is critical to ensuring the best possible mental health when entering old age.

Other gaps in the health services including the under-utilization by males of Primary Health Care need to be addressed. Given the levels of chronic disease, increasing mental health issues and changing family dynamics, the issue of care-giving is becoming increasingly significant. Informal care given by family and paid care-givers provides 80% of care of older persons. There are two main aspects to care-giving: those related to the actual activity, cost, training and services and those related to the caregiver, caregiver burden, burn out and support.

Healthcare needs to be provided along a continuum and include long term care. Long term care is more than residential care, as the earlier the intervention in the communities is, the more likely it is to maintain function. The current available services are mainly institutional with little community intervention except for that provided by churches and non-governmental organizations (NGOs). The continuum of long term care ranging from the provision of meals

and assistive devices such as glasses and walkers to residential care is needed to help reduce functional breakdown. There is the need for standards and regulations; financing is a major issue for families requiring care and cannot be ignored as a need.

Much of the discussion on financing had focussed on the increasing cost of healthcare assumed to be associated with population ageing and not on the total picture of financial need. While it is true that there are increased healthcare needs in the later years, there is research indicating that much of the increased cost is due to inflation, more technology and new treatment methods. Only 15% is due to ageing.

Given that 78% of the health budget in Jamaica is apportioned to salaries which have been increasing, there is added reason to reduce the need for care by reducing the level of chronic diseases and consequent need for services. Research will remain an important component of healthcare provision as each cohort of elderly persons is different and as interventions need monitoring and evaluation.

### Social Issues

As stated earlier, the social environment of older persons is changing, families are smaller, more women are working and living arrangements have changed and such changes are impacting on how older persons can be cared for. The question is: how does a developing country like Jamaica support what is now regarded as "ageing in place" or maintaining older persons at home?

The social aspects of ageing fall into two main areas: social security and meeting the social needs of older persons which overlap significantly with health and economic needs. This paper will not discuss social security programmes which are fairly well developed and simply need a better orientation to ageing issues. They need expanding based on a reorientation towards increasing function rather than reinforcing dependency.

Older persons like younger persons, have the same basic needs as described by Maslow (30). The first three levels are income related and retirement reduces the ability to continue providing for oneself. Age-related awareness is needed in existing programmes. Housing is a good example – older persons (78%) own their own houses but many cannot maintain or repair them so the traditional housing programmes which provide persons with a house will not meet the needs of an older person.

Transport and recreational facilities are other examples. There are also issues of accessibility and safety both at home and the community – falls being a major threat. The main problem identified by seniors is loneliness. The 5<sup>th</sup> level of Maslow's hierarchy; self-actualization and self-esteem, is not easily maintained after retirement, given the loss of independence both physically and financially and/or widowhood, all changes commonly accompanying old age (30). So social activities and recreational programmes with the necessary support are needed, and a system of early identification of problems so as to intervene early.

The changes in family structure and its impact on inter-generational solidarity have an effect on the provision of care so raising the issue of the care-giver again. These difficulties with families' care are not compensated for by the availability of formal services and require family support programmes.

Any discussion of the social aspect must recognize the contribution of the older person to social and cultural development. Some will argue that there is a political contribution as they are on the voting list. But improving the social environment will need to include strengthening human rights legislation, empowerment of older persons and a programme to reduce ageism and improve the image of "ageing".

## ECONOMIC ISSUES

While this area is not the subject of this paper, because of the interrelated nature of needs of the older person it has to be mentioned. Developmental discussions often focus on the costs of population ageing but that is a narrow although important focus.

Financial security in old age is made more necessary by the increased health needs. The increase in length of life fuels the pension discussions. Of concern for the current cohort of older people is the large number of persons not in receipt of any pension.

Currently, only one-third of the older population receive pension (6). This stresses not only the person but the

family and the relevance for this paper is the additional burden to caregiver.

In the broader sense, there is the need to integrate ageing issues into the development agenda using a life-course approach. This statement is cognizant of the importance of young persons and their needs but equally important is the fact that a country cannot ignore 15% (soon to be 20%) of its population.

Population ageing affects labour market supply and has implications for the workplace as the number of older workers (50 – 64 years) increase and younger workers decrease due to the fall in fertility and increase in the median age.

Consideration of the retirement age is needed. Given the projected labour force changes and the stated objectives of the Madrid Plan of Action and the Brasilia Declaration, both endorsed by Caribbean countries, training and retraining along the life span is needed. There is an area of overlap with health as workplace wellness programmes already recognized as having an impact on chronic disease reduction are needed throughout the private sector.

## WHAT FOR TOMORROW? THE WAY FORWARD

The way forward begins with the adoption of the active ageing approach defined as the process of seizing all opportunities for physical, social and mental well-being throughout the entire life course in order to extend healthy life expectancy (31). It involves taking individual responsibility for health and healthy lifestyle choices along the life course (32), recognizing that all that happens before age 60 years impacts on the quality of life after. That is the life-course approach (Fig. 8).

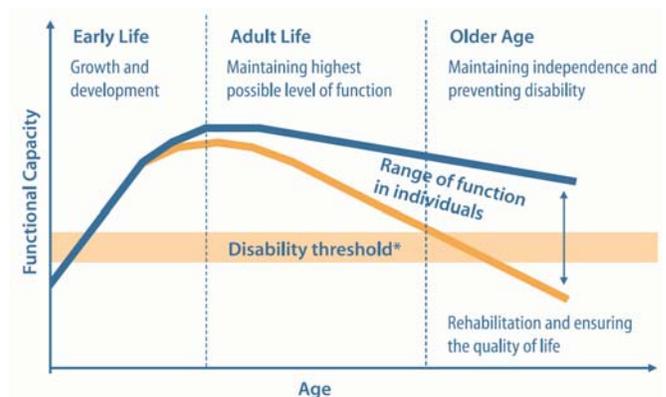


Fig. 8: Maintaining functional capacity over the life course

Source: WHO 2002

Kalache and Kickbusch, 1997

Implicit in the active ageing approach is the mainstreaming of ageing into the country's development agenda and ensuring ageing is linked to other frameworks for social and economic development, irrespective of the stage of development.

Policy which addresses or includes an ageing related component needs to be informed by the timing and level of population ageing as well as the magnitude and speed of the change. The changing balance between the age groups will also be a deciding factor. The window of opportunity is now with twenty years of lead time remaining for policies and programmes to be implemented. The response, assuming there is one, will need ongoing monitoring and necessary adaptation. Changes in economic growth and/or stability, a disaster and the HIV/AIDS epidemic can influence population ageing overnight. The HIV/AIDS impact on population ageing in Africa is a good reminder.

The response/way forward will need to be general but also specific addressing the components of ageing (Fig. 7). The response will need to take place at several levels beginning with the individual who needs to take responsibility for their own healthy ageing, the private sector for whom there are business opportunities (and not just in the area of pensions), the voluntary sector and finally the Government. In short, everyone in society needs to respond.

There are some areas for action. These are not exhaustive, but are mentioned rather to stimulate discussion and action. They are in addition to all that is being done already by both Public and Private Sector.

## **SOCIAL**

Given the developments during the 1970s and 80s in the area of Social Policy and Programmes, much has been done. However, they need to be maintained, modernized and expanded using the developmental approach.

Caregiving will increasingly become an issue. Caregiving is mainly provided by the informal system (80%) which is increasingly becoming more difficult for reasons discussed earlier.

The way forward by necessity will have to include support of caregivers including physical, financial, provision of supplies (incontinent pads, walkers) and assistance in meeting the health needs. It is important to recognize that not only does the caregiver (usually a middle-aged female) have needs related to the senior but her/his own needs related to her/his ageing process. One suggestion is the addition of a geriatric community worker to either the health or social teams, and better still both, presuming horizontal integration can be achieved. The Caribbean state of Antigua and Barbuda includes this as part of youth service. Resource constraints, both human and financial, cannot be an excuse to do nothing – a way must be found. Clearly a mix of public-private service is the way forward with those who can pay for service. A great resource in designing options is the young old (60 – 74+ years) age group who do much now in families and communities.

One can build on the spirit of volunteerism, design programmes and provide training and help churches organize efforts.

After the basics of any Social Service have been identified and implemented, then one has to think creatively and expand them. Housing developments should include age-friendly designs. More and more services will be “rights” driven rather than needs driven. Importantly, the institutional arrangements for identifying older persons on the borderline of “need” require strengthening to provide early intervention and prevent the need for institutionalization. It is recognized that health needs will be a big part of what constitutes “need”.

## **FINANCIAL/ECONOMIC**

Providing pensions which are adequate and can last for the increased years of life is a challenge that not even successful developed countries have been able to do. But we must try. There are two major issues. The first is how to get young persons faced with all their financial obligations to recognize the importance of making pension arrangement and contributions. The second is pension fund management. It is in this area that the window of opportunity is particularly important. The increased number of persons of working age, given adequate employment opportunities, can be a boom to pension funds.

There are workforce related issues which need recognition and attention. There is a vital role for employee organizations including Trade Unions in providing solutions for population ageing. The International Labour Organization (ILO) has been providing blueprints and policies, but little action is evident so far (33, 34, 35).

The changes in the age and size of the workforce mean more older workers. Management of the labour force will need to implement strategies to improve and facilitate older workers. Suggested strategies include an examination of retirement age, flexi-retirement and flexi-work options. Today's older worker entered the workforce before much of the industrialization and technological development and so many need training to stay employable (36). Very important and necessary will be training and retraining programmes. The myth that older persons cannot learn must be dispelled and life-long learning opportunities adopted (36, 37). Universities and training institutions can and should provide leadership with “third age” opportunities.

Workplace wellness programmes including exercise opportunities and expansion of day care facilities beyond the current child care are needs of the ageing population. Occupational health programmes which recognize age-related changes will help. And the vexed issue of post-retirement health insurance needs lobbying for. All these should form part of union negotiations (38).

## **HEALTH**

Health is a development issue as economic development is dependent on healthy persons. The goal of successful ageing is not only an increase in length of life; but also, an im-

provement in the per cent of life lived in good health, free of disability; functional ability and independence not presence or absence of disease being the important parameter. Health here is used in the broadest sense – mental, social economic, spiritual and physical (39).

Much of the discussion in developing countries has focussed on the perceived increased cost of providing healthcare to the old especially in the last year of life. Studies have shown that these concerns are exaggerated and that healthcare costs are more a function of how systems are organized and financed and technological advances than population ageing (40, 41). As such, the financial increases can be averted by appropriate policy interventions.

For this discussion, it is recognized that changes in health status have many dimensions – diseases, impairments, loss of function, disability and eventually death. In examining the way forward, there is a solid foundation already well established on which to build – that is, the importance of health promotion. The value of health promotion in older persons has been demonstrated in several studies (31, 42). It should be realized that healthy life-styles need more than behaviour change and should include age specific approaches. To be successful, people need the means to participate in society and therefore be able cope with life.

The older population after retirement is the age group for which this need is least met. Of equal importance is knowledge. A national programme on age-related changes and their implications is needed beginning in schools and extending throughout life. It is needed also for all persons including health-workers.

The health response will need to have a positive integrated approach which includes social, economic, housing and transport policies that are age-sensitive and age-friendly (43). The health promotion principle of enabling environments is critical to success. It should also be recognized that health promotion in older persons must include a focus on preserving functional ability (Fig. 8).

Jamaica has been piloting the Age-friendly Health Care approach for WHO (43). The existing primary healthcare system provides the vehicle and all the following suggestions assume this is the base to build on and recognize the current efforts of the Family Health Unit in the Ministry of Health to strengthen it. The general health strategies must be community based fostering family solidarity and community participation that will need to be supported by adequate secondary and tertiary care and effective communication systems. Some possibilities include:

#### C Health Strategies

- o Introduce age-friendly approaches in PHC islandwide and introduce the concept into Accident and Emergency departments
- o Strengthen education on prevention and on improving motivation in later years among all health and social work personnel

- o Introduce earlier interventions to preserve function and promote functional independence through integrated approaches using all community resources
- o Implement a paradigm shift from episodic to continuous care in PHC
- o Promote and support family care by providing a range of community services, home services, residential services, community services and institutional care (Table 10)
- o Improve integration of health, social and community services including voluntary and church efforts
- o Training of healthcare staff in ageing and age care. Review all curricula and ensure the inclusion of gerontology and geriatrics
- o Improve the public/private/voluntary group coordination

All actions need to be supported by quality assurance efforts. It is vital that appropriate standards and regulations be in place with adequate monitoring systems. The main drawback to the suggestions made is inadequate resources both human and financial. The resource constraints will need to be addressed or none of the above will be possible and in 2030, policy makers will suddenly be faced with 20 per cent of the population or over 500 000 persons to make provision for. There is a need for creative approaches. Consideration should be given to some of the specific issues that the research has identified. Men's health and specific cancer screening and early treatment are two areas.

## CONCLUSION

The ideal of comprehensive PHC supported by adequate developmental policies and social security systems is the best way forward for developing countries such as Jamaica and should be one of the stated components of healthcare reform and all developmental policies. Its success will be dependent on the strengthening of the public health system and on sustained economic development. It will equally be dependent on public-private partnerships and on each individual taking responsibility for their own active ageing programme and ownership of the planning process.

Success depends on ageing being accepted as a development issue accompanied by the necessary political will to ensure it is included in policies and programmes supported by adequate resources. The success in the reduction of infant mortality and maternal mortality show it can be done. The baby friendly initiative is another success. The cost effectiveness of these programmes is no longer questioned as they are quoted as public health successes.

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