Primary healthcare for older people

A participatory study in 5 Asian countries

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A participatory study in 5 Asian countries

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Foreword

This document was prepared by the HelpAge International network in Asia/Pacific and it summarises the perceptions of older people and health service providers in five countries of the region. Its purpose is to generate discussion and by no means does it represent a scientific study of the primary health sector at a given time. Nonetheless, it is important to note how the needs, gaps and shortcomings are highlighted by the older people themselves.

Population ageing will have an enormous social and economic impact in Asia, where one-third of all older people will live by 2025. It is projected that there will be over 1 billion people aged 60 and older in Asia by 2050. When these numbers are placed in the context of health services for older people, there is a growing apprehension of how current health systems - infrastructure, health personnel, and budgets - will meet the increasing demands for these services.

With global ageing, chronic disease is also a growing threat worldwide, with 60% of all deaths now attributed to chronic disease - twice that of the rate for infectious disease. Cancer rates in Asia are anticipated to exceed the rates in the Americas and Europe by 2030, and the incidence of hypertension and diabetes are showing rapid increases, with Type 2 diabetes affecting 12% of the population in India and hypertension affecting 19% of the population in China. Death rates attributed to chronic disease are as high as 83% in Singapore.

The good news from the WHO is that most of these premature deaths as well as associated disabilities can be reduced through the application of active and healthy ageing principles, and by governments leading the way in prevention through the delivery of effective primary healthcare services. As this study of primary health care in 5 countries points out, there are poor quality primary healthcare services provided to older people, especially in rural areas.

There are many reasons why older people are not accessing services, although the cost of healthcare is the primary barrier, as mentioned by older people in all of the five countries involved in this study. The services provided by primary health care centres represent a key instrument in combating the increasing prevalence of chronic disease and associated disabilities, as well as supporting the quality of life of older people. In addition, it has been shown in numerous studies in the United States that primary healthcare centre delivery is cost-effective. For example, Macinko et al (2007) showed that with greater numbers of primary physicians, there was a correlation with the health outcomes in terms of cancer, heart disease, stroke, infant mortality, etc.

It is imperative, therefore, that governments and civil society work together to support the delivery of comprehensive primary healthcare. It makes sense to support the healthy ageing of older people; for those countries with the political will, improvements in primary healthcare delivery for older people will not only lead to overall human development but also economic savings that can be used of other valuable purposes.

Dr Mary Ann Tsao
President
Tsao Foundation

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The HWG members would like to express their appreciation to the older people, the care-givers, and the primary health practitioners who participated in the research and provided their time and responses. We hope that through the discussion of this report, more awareness will be raised in relation to the situation of older people and primary healthcare, and that governments, multi-lateral institutions, and civil society will take this report into account in developing policy and programmes related to healthcare for older people in the Asia-Pacific region.

Chapter 1: Introduction

Chronic diseases are commonly thought of as a "Western world" health problem. This perception is changing, however, as chronic diseases in low and middle income countries now contribute to nearly as many deaths as communicable diseases. The WHO report, *Preventing Chronic Disease: A Vital Investment*, states that "80% of chronic disease deaths occur in low and middle income countries . . ."[1]

Average life expectancy in low and middle income countries has increased from 50 in 1965 to 65 in 2005.[2] Greater life expectancy means greater numbers of older people who are more vulnerable to chronic disease. 9.4% of the population in Asia is 60 and older, and shifting demographics will result in a greater number of those aged 60 and older compared to those aged 14 and below by the year 2035. Asia will be particularly affected by the greater burden of chronic disease as its population of older people will account for 1/3 of all older people in the world by 2025.[3]

Although progress has been achieved in reducing the impact of infectious diseases, the issue for many low and middle income countries is that they now must address two co-existing health threats, both infectious and chronic noncommunicable diseases. This is known as the 'double burden' facing healthcare systems in low and middle income countries. This is already a reality for India, as an example, where deaths from chronic diseases account for 53% of all deaths in 2005, and where communicable, maternal and perinatal and nutritional deficiencies account for 36%.[4] The WHO projects that over the next ten years deaths attributable to chronic disease will increase by 18% in India.[5] Dr. S.C. Chandra, Head of the Department of Medicine and ECG services at Sanjay Gandhi Memorial Hospital, points out the dilemma faced in India:

> *"Earlier August and September were malaria and dengue months. We used to keep wards vacant for those patients. Now with all the diabetic and cardiac patients there's no space for them."*

Most Primary Healthcare (PHC) systems in Asia have focused on the threat of infectious diseases given their historical prevalence. There is now a need to reformulate policies to address the new reality.[6] As this study demonstrates, there is currently a lack of quality primary healthcare services to address the growing threat of chronic illness. Comprehensive primary healthcare for older people represents a holistic approach that will promote active ageing, reduce and prevent chronic disease with its attendant disabilities and dependencies, and improve the quality of life for older people. Implementing such an approach will have the added benefit of supporting the country's overall socio-economic development, as well as achieving the commitments made at the United Nations Second World Assembly on Ageing.

1 WHO (2005), *Preventing Chronic Disease: A Vital Investment*.

2 World Bank (2007), *2007 World Development Indicators,* and on-line Life Expectancy Chart.

3 United Nations (2002), *World Population Ageing 1950-2050*.

4 WHO (2005). See http://www.who.int/chp/chronic_disease_report/media/impact/en/index.html

5 WHO (2005). See http://www.who.int/chp/chronic_disease_report/media/india.pdf

6 In the WHO Secretariat Report on prevention and control of noncommunicable diseases, it notes that "the proportion of countries having a specific budget line for chronic noncommunicable diseases increased from 39% to 68%. Nevertheless, the proportion of the health budget spent, in general, on prevention and control of chronic noncommunicable diseases remains very small. Even a minor increase in that proportion would yield tremendous health and benefits." WHO Report by Secretariat to the Executive Board, 120 th Session, January 8, 2007.

Chapter 2: Purpose of the study

The purpose of this study is to document the perceptions of older people, care-givers, and health service providers in terms of knowledge of active and healthy ageing, access and quality of PHC services, and the experiences of older people in managing stroke and diabetes conditions. Recommendations to improve PHC services are also provided to support policy development in the Asian context. The study was conducted in June-July 2007.

The 5 countries participating in the study are Cambodia, India, Indonesia, Singapore, and Vietnam[7]. These countries were purposely selected because they represent the variety of socio-economic conditions in the region. This study also purposely examined the conditions in rural, urban and tsunami affected areas (in India and Indonesia) in order to provide additional insight into possible geographical discrepancies in provision of PHC services for older people. There were a total of 356 older people, 33 care-givers, and 40 health service providers who participated in the study.

The study was not intended to be a comprehensive analysis of the healthcare provision in the countries, nor is it a quantitative study on the impact of these systems on older people's access to PHC services. It was designed to provide a snapshot of perceptions of representative groups of older people, their care-givers, and healthcare providers in relation to primary healthcare services.

7 The study was conducted by members of the Health Working Group (HWG) of the HelpAge International Network. The country research was facilitated by HelpAge International Asia-Pacific Regional Development Centre, HelpAge Cambodia, GRAVIS, InResAge (Trisakti University in Jakarta, Indonesia), the Tsao Foundation, and the Southern Institute of Social Sciences of Vietnam.

Chapter 3: Health conditions of older people

The study assessed the common health problems among older people. In all of the countries, the majority of older people self-reported that they had at least one chronic health condition, and in many cases multiple chronic illnesses. Hypertension was the most frequent chronic illness reported in India, Vietnam, Indonesia, and Cambodia, with cardiovascular disease and diabetes to a lesser degree; whereas, in Singapore, diabetes was the most common chronic disease reported by older people. Other conditions, such as joint and bone disorders, gastro-intestinal disease, and cataracts, were commonly reported by older people in all of the countries. Participants in India and Vietnam also reported chronic lung diseases as a common condition among older people.

It should be noted that the health conditions among older people in the study are self-reported, and thus based upon the health awareness and knowledge among older people. The health conditions may be under-reported due to infrequent health check-ups and inability to assess their own symptoms. However, many of the healthcare practitioners also confirmed the frequency of chronic illnesses among older people:

> *"The elderly commonly suffer from hypertension, diabetes, heart diseases, and chronic lung diseases. There is also a gender difference between the different types of diseases. For example, elderly women get more diabetes and osteomalacia while elderly men are more likely to get strokes."*
>
> Physician and Director of the Geriatric Department
> Nguyen Trai Hospital, Vietnam.

Both older men and women who are in older age brackets are more prone to chronic noncommunicable diseases, with greater chances of having functional limitations. While deaths from chronic disease affect older men and women equally, older women in developing countries have longer life expectancies, and thus there are more women in the oldest elderly groups (75+ years). As the WHO points out, "For women in developing countries who survive the early lifespan stages to reach middle age, life expectancy approaches that of women in developed countries. At age 65, women in developing countries now have about three quarters of the remaining life expectancy of their counterparts in developed countries, and the gap will narrow in the future as mortality steadily declines at younger ages."[8] Based on life expectancy data, studies conclude that in both developing and developed countries, "women can generally expect to spend more years of their lives with some functional limitations than men."[9] The implication is that the primary healthcare needs of older women, who contribute substantially as care-givers and supporters of the family, require special emphasis from healthcare practitioners in order to prevent disability and improve the number of years of healthy life.

8 WHO (2000), WHO Fact Sheet No. 252. See, http://www.who.int/mediacentre/factsheets/fs252/en/index.html

9 Ibid.

Chapter 4: Knowledge of active ageing, healthy ageing and the life course approach

The term 'active ageing' was developed by the WHO in the late 1990s. It was further expanded as a policy framework by the WHO as part of its contribution to the Second United Nations World Assembly on Ageing (Madrid, Spain, April 2002). The concept is intended to enable people "to realize their potential for physical, social, and mental well being throughout the life course and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance."[10] Healthy ageing and the life course approach is one aspect of the active ageing framework. It recognizes that noncommunicable diseases are more prevalent in the later stage of the life course, although the risks for chronic conditions develop in early childhood. Healthy ageing and the life course approach therefore addresses these risks through early to later stages of life, with differing needs according to the timeframe.

'Sometimes, I don't really want to ask the doctor about my condition. They are busy, and sometimes don't really want to elaborate ...'

Older female focus group participant, Singapore

Primary healthcare services for older people can play an integral part in healthy ageing and the life course approach. PHC services can support health promotion, disease reduction and prevention, early diagnosis, and effective management of chronic illnesses.

The reality of primary healthcare services in these five countries is that healthy ageing and the life-course approach is not well-understood or applied by the healthcare providers at the primary level. In the area of health promotion, health care providers typically do not spend time with the older person to encourage the development of behavioral changes (for example, healthy diets and routine exercise) that can reduce the risks of chronic illnesses. Even in Singapore, where the knowledge among PHC providers of healthy ageing and the life course approach is high, medical check-ups of older people are not routine (hindered by costs). The time spent with older people is limited, with the majority of the time spent on diagnosis and treatment rather than on education and prevention.

Furthermore, healthy ageing and the life course approach is not a subject that is included in the school curriculums in the countries. Educating the youth in society is a way to prepare the next generation for active and healthy ageing.

Recommendations to increase awareness of healthy ageing and the life course approach:

- Promote primary healthcare worker's knowledge of healthy ageing through training
- Initiate public health education campaigns on healthy ageing, risk factors, disability, disease management, and positive images of ageing and older people
- Incorporate the topic of healthy ageing in school curriculum to promote health throughout the life course
- Encourage the intergenerational relations that provide understanding, rapport, support and responsibility among the young, adult and older generations to support the life course approach to ageing

10 WHO (2002), Active Ageing: A Policy Framework

‘I can’t remember when I went to see a doctor last time. I have pain in my joints, my vision is poor and I have a breathing problem too. But, I don’t have the capacity and resources to go to a doctor. Why is healthcare so expensive and scarce?’

Ms Jhamu Devi, 67
Rural India

Chapter 5: Perceptions of primary healthcare and recommendations

5.1 Availability

The availability of primary healthcare services was a concern of older people in rural areas. The study found that older people in the urban areas had readily available primary healthcare services. However, older people living in rural and tsunami affected locations are not as fortunate. The healthcare facilities in these areas are scarce. In Rajasthan, India, only 2 health centres were found to be functional and in the tsunami affected area of Tamil Nadu, only 3 health centres and 1 hospital existed. In Vietnam and Indonesia, there are more facilities available to older people; however, those facilities are found at considerable distances. While in Cambodia, older people travel an average distance of 5 kilometres to reach the nearest available health centre.

The distance to these services was also significant, especially in India and Cambodia. For example, in India, 69% of rural respondents reported distances of 20 kilometres or more to the public facilities. Rural respondents adapted to distances by relying on the use of local community knowledge, traditional medicine, and private practitioners for their primary care. Older people in Singapore reported no difficulty in availability of facilities for primary healthcare, both private and public, although lack of age-friendly affordable transport impedes access to services

Recommendations to reduce the physical barriers to accessing primary healthcare centres:

- Ensure there are sufficient number of PHC centres that are located at reasonable distances for older people
- Review and strengthen the public transport system to ensure it is age-friendly and affordable to older people
- Review and strengthen the physical environment, for example, inclusion of older people in designing new PHC centres, the centres planned and constructed with age-friendly features, and renovate older centres to incorporate age-friendly features.[11]

5.2 Accessibility and affordability

The ability to access services of the facilities was dependent on a variety of factors. Older people reported that they had never had a health screening or that it was very infrequent, which indicates minimal utilization of preventive primary healthcare services. However, many of the reasons for not accessing services were not only based on availability but also on preferences and attitudes of older people. Older people indicated that they only accessed these services when they experienced a health problem which affected their ability to carry-out daily activities, and costs were the main reason cited for not accessing services.

Older people also expressed the need for accompaniment, and in urban areas this was often difficult to achieve.

> *“My family is busy working so there is no one to take me to the doctor. How would I go?”*
>
> Older man[12]

11 Key features of the age-friendly primary health care are available in the WHO publication, Towards Age-friendly Primary Health Care.

12 HelpAge International, *Uncertainty Rules Our Lives: the situation of older people in Bangladesh*, p. 20.

Also, in urban areas, older people were concerned about seeing a familiar doctor which was not always possible, and impacted their desire to access services. In rural areas, older people preferred not to leave their local area, with special concerns about tending to daily chores and grandchildren. Thus, even in urban areas where services are readily available, older people have preferences which impact their frequency in accessing these services.

The experience in use of the public facilities was a factor. Older people found there was poor information available on the options for treatment and care of diabetes and stroke, and a lack of medicine for treatment. In Cambodia, local private practitioners had access to medicine, whereas public health centres frequently did not, which affected patients' desire to use these services. Long waiting times was another barrier to accessing services in all of the countries, and especially in Singapore where a visit to the polyclinic can take as long as 4-5 hours. Distances to the facilities, poor physical environment to accommodate older people, and lack of age-friendly staff were also cited in most countries as reasons for not accessing primary healthcare facilities.

One physician in Jakarta, Indonesia, commented about the barriers that older people experience there:

> "*There are very short consultation times, language problems (the older person does not understand Bahasa Indonesia), further costs, the patient's educational level as well as their caregiver, the location of puskesmas (health centres) far from older people's homes. I think these are all the obstacles that older people are faced with.*"
>
> Female physician at the Pasar Minggu Health Centre
> Jakarta, Indonesia

'Only when I feel tired or sick will I go to a doctor. If the doctor finds an illness, I have this treated. I do not have health checks periodically because I have no money to do it.'

Focus Group Participant
District 9 , Vietnam

Recommendations to reduce the cost and other barriers to accessing primary healthcare centres:

National budgets

- Develop adequate budgetary allocations for affordable PHC services for older people, which includes allocations for health promotion, prevention, management, diagnostics, medicine (both standard and patented), and home-based care

Income security of older people

- Support the introduction and strengthening of cash transfers and other social protection schemes, which will ensure ability to pay for PHC services

Socio-cultural barriers

- Mainstream ageing, gender, ethnicity into the policy planning and programme development in relation to PHC for older people

Disaster risk reduction

- Develop disaster risk reduction plans that take into account older people (as a vulnerable group), and ensure older people are included in the planning, design and implementation of plan

5.3 Appropriateness

The comments relating to the quality of health services were commonly poor. For example, in Cambodia respondents stated that they rarely received knowledge about their condition from the practitioners, and in the public health centres they were provided with little medicine for treatment. This was also true in Vietnam:

> *"It is the regulation of the healthcare system that health stations have to organize annual health examinations but they do not provide medication for the old. The first time we organized it, many old people were eager to participate. But they recognized that we just did blood tests for them, and did not receive any medication, which they viewed as ineffective. After the first time, they have since been reluctant to continue examinations and there is only a participation rate of 50 percent because they think health examination without medication is ineffective for their health"*
>
> Chairman, Vietnam Association
> of the Elderly Long Son Commune Branch

Lack of effective services was also common complaint among rural respondents in India. No geriatric expertise was available in either rural or tsunami-affected locations in India. This was also true of rural areas in Cambodia and Vietnam; whereas, the local clinics in Indonesia are required to be staffed with a primary care physician with training in gerontology. In more urban areas, the quality of services was considered to be better; however, many older people in urban areas also believed that the medicine they received was ineffective in treating their condition. In Vietnam, for example, an older person pointed out the restrictive nature of the medical insurance in obtaining medicine:

> *"I have healthcare insurance. When I go to the hospital for health checks, the doctor gives me only medication made in Vietnam. Moreover, I have to wait a long time for the doctor. So, when I get sick, I just buy medication at the pharmacy to treat myself. Medication I get from my healthcare card is not effective. Thus, my healthcare card is useless. I am fed up with the way doctors treat patients who have healthcare insurance. I do not want to have healthcare insurance."*
>
> Male focus group participant
> District 9, Vietnam

In Singapore, the respondents reported that the quality and age-friendliness of PHC facilities had improved considerably, and they were mostly satisfied with the quality of care they received. It is projected, however, that with increasing affluence and education, the next generation of seniors will have higher expectations of the comprehensiveness of care.

Recommendations to improve the quality of PHC services:

Training and capacity building

- Ensure healthcare professionals (including medical doctors, nurses, community health workers, and traditional practitioners) receive appropriate training in healthy ageing and geriatrics
- Ensure care-givers receive appropriate training (both formal and informal) on ageing and elderly care

- Carry-out self-management training (patient education) for older people with chronic diseases

PHC facilities

- Ensure that PHC centres are adequately equipped and provide age-friendly health and social services

Exchanges

- Support the sharing of experiences through exchanges and best practices that support the overall development of PHC services

5.4 Integration

Most poor older people with minor ailments indicated a reliance on local community health workers, such as the private health practitioners, local pharmacists, and traditional practitioners as alternatives to the primary healthcare centre services, which they felt were less convenient and not reliable. The added value of public primary healthcare centres was mostly found in cases where their illnesses were severe, and then they could be referred to a district or provincial hospital for specialized treatment. This study did not examine the referral and integration systems between primary, secondary and tertiary care. Nevertheless, the integration of services between the private and public system is quite poor. Thus the history, diagnosis and treatment of patients are frequently lost and require additional time for tests and information gathering.

In Singapore, the polyclinics have a system for documenting medical information, although the older people complained they saw a different doctor on each visit. There is a new polyclinic programme offering longer consultations and the guarantee to see the same doctor; however, the expenses for consultation are also considerably higher. The participants in Singapore nevertheless indicated a preference for this programme.

Singapore was also more advanced than the other countries in integrating medical and social care of older patients. A Medical Social Worker in Singapore explained that polyclinics are more attuned to social care needs of patients, allowing receptionists and nurses to refer patients who need financial and other psychosocial care to medical social workers.

In general, there is a high turnover of primary healthcare practitioners in the rural areas in most countries, which also impacts the coordination of care for older people. As explained by a physician in Vietnam, staffing of clinics is a significant issue:

> *"With low income, doctors at commune/ward clinics have to always undertake field work. So they are fed up with the system. Attracting doctors to work here is a difficult one. They cannot find a job in large hospitals, so they work here for a short time until they find better positions in the city."*
>
> Physician and Director of the Co Giang Ward Health Clinic

Recommendations for improving the integration of PHC services

Medical care

- Ensure coordination between PHC facilities and other health facilities, such as hospitals, long-term care providers, and specialists
- Ensure coordination between PHC facilities and other organizations, such as Older People Associations, community-based organizations, traditional healers, and insurance providers
- Develop older people-centred care policies, rather than a disease-centred orientation

Social services

- Introduce and strengthen systems that provide linkages and formal coordination between PHC facilities and social support services that address day-to-day and psychosocial needs of older people

Chapter 6: Stroke and diabetes

6.1 The experiences of older people

The study was also designed to examine the experiences of older people who have diabetes or have had a stroke. These two conditions were selected because the prevalence trends in Asia are rapidly increasing for these conditions, and because these conditions commonly result in disability, impacting not only the individual but also the family and the community.

The first case study is from rural Cambodia, and highlights the debilitating impact of stroke on older people, and suggests that the lack of affordable primary health care services results in the poor prevention and management of chronic illnesses.

Case study 1: Stroke and health services in rural Cambodia

"All of a sudden, I felt cold, my eyes were weak, and half of my body became suddenly unresponsive. I was trying to get up and put on my shoes, but I could not find them," recalled Mr. Chong Hong of the moment and symptoms he suffered from high blood pressure-induced stroke 10 years ago. His children took him to public hospital for a week, where he was told that he had had a stroke. It was then that he learned he also had high blood pressure. He explained that a lot of older people in his village suffer from diseases without the knowledge of a diagnosed condition. Mr. Hong is 74 years old now and lives with his youngest daughter, 28, and her family in a village in Battambang Province. Mr Hong was a farmer until the stroke paralyzed his upper left arm and left him unable to work.

Currently, the family is experiencing deep financial problems because they have no regular income. His daughter who has been his care-giver has borrowed money from neighbours, with an interest rate as high as 80% per year, to purchase medicines for her father. She has accrued a sizable debt.

Mr. Hong resented the fact that he could not longer work to earn money, and that his paralysis and high blood pressure could not be completely cured. He said he especially missed not being able to go to the Buddhist temple to pray.

The health services he received were irregular and sporadic. Because of financial reasons, Mr. Hong could not afford a regular health check, and only sought health service when he experienced a downturn in his condition. Even when his daughter could save enough money for a check-up (e.g. blood pressure test), the local private health worker no longer offered the test because is was not profitable. He didn't receive any advice on physiotherapy. Despite the lack of regular treatment, Mr. Hong felt that his condition has improved and he has not experienced serious complications from the stroke.

Because his daughter is able to stay at home, she provides him with adequate care. "My daughter helps me a lot with my everyday life, cooking me rice, washing my clothes, buying me medicines and anything else that I may need," he said. The main barrier to receiving good healthcare was perceived to be money. Once in a while, his condition becomes very serious and that leads to crippling financial problems as his family needs to borrow a lot of money (30 to 40 USD) for his care.

Cont'd...

'The things I do to keep myself healthy are taking medicine, doing some exercise in the morning and not eating food that is too salty or sweet; I don't have the money to go see the paet chhnoul (local private health service provider) regularly.'

Mr Hong, 74 years old
Battambang, Cambodia

Mr. Hong is very worried about his future. He's getting older and his condition could deteriorate much faster, especially with his family's unstable financial condition. All his children are poor and struggle to survive themselves. He's very concerned that the neighbours may stop lending the money when they see he or his children are not able to repay. When asked about public health service, he responded, "the local health centre does not have the medicine I need; and it costs just as much to go to big hospital." He further commented, "you can see now I am much weaker because I do not have the money to buy enough medicine or have my blood pressure tested. Whenever the weather is hot, I find it hard to breathe. I become uneasy and cannot stay still; I'm so worried."

The second case study comes from urban India. This study reveals that poor, older people face an up-hill battle in accessing primary healthcare services, and that their loss of physical mobility results in further economic hardships, as well as social exclusion by family members.

Case Study 2: The pain of poverty and disease

Seventy-two year old Fazal Ahmed was diagnosed with Diabetes two years ago. At that time, he used to run a small cloth-selling business in a slum of Sultanpuri in Delhi. His job required him to move frequently to procure orders. During the past two years, his health deteriorated drastically. Acute pain in his legs has rendered him incapable of moving. He suffered losses in his business and had to close it down. With the loss of livelihood and the burden of the disease, he was abandoned by his young sons. Today he is fighting hard to keep the wheel of his life moving.

He lives with his wife and a young daughter who is a widow. Life for them continues in extreme poverty. He neither has the resources nor the energy to buy expensive medicine. He gets his medicines from a locally trained medical practitioner who lives close to his house. The treatment that he gets is sometimes helpful and sometimes not. He understands that he needs better healthcare services but he just does not know how to get that. The future is bleak for Fazal. "Somebody should do something for people like us," says a weak and hopeless Fazal Ahmad.

The final case study is from Singapore, where there is good access to PHC services. Nevertheless, the case study shows that older people lack knowledge to prevent chronic illness, and that a lack of education contributes to poor communication between the older person and the healthcare practitioner, resulting in poor self-management by the older person.

Case study 3: The experience of a Chinese diabetic patient in Singapore

Madam L is a 70 year old Chinese diabetic patient, who is widowed and lives alone. She resides in a one-room government flat, and her son, grandson, elder sister, and nieces/nephews assist her with her financial expenses. She visits the nearby government Polyclinic every 3 months (HBP). She has suffered from HBP since age 30, and found out about her diabetic condition 5 years ago. She has mild diabetes, and she stated that

Cont'd...

she was not advised on her diet and other preventive measures by the doctor or nurse. She also has frequent back pain caused by spinal problems. She was hospitalized for this some year back.

The various illnesses have caused her to be restricted in her mobility, unable to carry heavy things, unable to squat or mop the floor. She gets depressed over the impact of the diseases on her daily life, and at times worries about her financial condition too.

"When I visit the doctor myself (alone), I am worried that I will fall down. It is inevitable that one is scared. But there is no choice, even if I am scared . . . I still have to go . . . I always ask God to help me."

She has no companion to accompany her to the polyclinic, and this adds to her anxieties. She is uneducated, hence is not aware what the different medicines are for.

The communication between the doctor and patient is limited if the doctor feels that the patient is uneducated and therefore, will not understand. As the respondent has mobility problems, she has to take a taxi for every medical appointment, and this increases her expenses.

She was on the whole, satisfied with the health services, and the attitude of the doctors and nurses. The following quote illustrates how important the patient's behaviour and attitude is for a cordial relationship. She says, "I will thank the Indian nurse in Tamil. It's just a form of courtesy. But she is happy and I am happy."

'When I visit the doctor myself (alone), I am worried that I will fall down. It is inevitable that one is scared. But there is no choice, even if I am scared . . . I still have to go . . . I always ask God to help me.'

Madam L, 70 years old
Chinese diabetic patient
Singapore

6.2 Lessons learned from the case studies

These cases reveal that, regardless of the location and relative income levels, older people and their families face severe financial and emotional stress when dealing with chronic medical conditions, and access to knowledge and appropriate treatment is very often difficult to obtain for older people. Additional lessons learned from older people with diabetes or stroke are summarized below.

Heath education and training

Health education should be provided at different stages of an older person's illness. It should be preventive in order for older persons to remain healthy as long as possible. It should provide guidance especially the health consequences for older persons already suffering from the disease. Health education should be provided to the older person, formal and informal caregivers, so that the older person does not feel alone and has various people around him/her for support such as health provider, informal caregiver, peers and family members who are able to share and provide solutions for older persons suffering from a degenerative disease.

In the case of older persons with stroke, their informal caregiver should be trained in fall prevention, rehabilitation exercises and disease management due to the frequent occurrence of falls in the older population. It is estimated the older the person, the more likely they will fall (one out of three). Even among institutionalized older persons the rate of falls is two per bed annually.

In the case of an older person with diabetes, health education should be focused on the early signs of complications, as well as eating a regular, balanced and nutritious diet. For those with more advanced disease, the informal caregiver in the home should be trained to provide insulin injections at regular intervals while making sure that the older person eats at regular intervals.

Quality of primary healthcare services

Visits should be scheduled to allow the physician to spend more time with their elderly patients. There should be a system in place to enable frontline health workers (such as health workers or front desk staff) to coordinate visits, investigations, referrals, medications for older people at the PHC facility. When communicating with older people, the health provider should demonstrate respect to the older person, allow the older person to make choices and always maintain the older person's independence. In multi-ethnic or indigenous societies, the health provider should be able to understand the local dialect or have a qualified translator available. For home-bound elderly, as far as possible, the local health facility should provide or network with a home care service or nursing service to provide home visits. Providers should be familiar with the WHO Age Friendly Principles for Primary Health Care Centres and be continuously trained in geriatric competencies, including long term and palliative care. Although the PHC facility may not provide the range of required medical and social services, there should be a formal referral and coordination network in place.

Affordable medicine

Government should provide subsidies for life-saving drugs especially for geriatric conditions. In India, Vietnam and Indonesia, disadvantaged elderly are presently able to access a range of generic medication. However, patent drugs for more difficult conditions especially suffered by the oldest elderly groups (75+ years) are still inaccessible for this senior age group. In some countries, such as Singapore, only drugs on a standard list (includes generic and patent) are subsidised. In the future, older people with low-middle incomes may not be able to afford patent drugs that are mostly used to treat the most difficult cases, and where the generic drugs may not be as effective.

Social support

Most treatment plans for people with diabetes and stroke involve exercise, and group exercise is often recommended. Group activity has two benefits: namely improved health status as well as improved mental health through peer sharing and support. Chronic diseases such as stroke and diabetes increase the risk of depression or low mood exacerbated by financial worries related to the cost of treatment, inability to work and dependence on the family. Care-giver support, patient and care-giver support groups and other social activities play an important role in overall disease management.

Community care

More community-based activities (including education, socialisation, support for activities of daily living, rehabilitation, etc.) should be facilitated and mobilized to enable participation by the growing number of older persons with disabilities related to chronic diseases. For single older people, those abandoned by family members or those with inadequate social support, community care plays an even more essential role.

Chapter 7: Other health related issues for older people

The study found a lack of available primary healthcare services for older people, especially in rural areas. Besides primary healthcare, there is a need for a range of public policies and adequate funding to support health issues for older people as outlined below.

Mental health

There is growing recognition of the threat of mental illnesses in older people in Asia, and especially among older women who live longer than men. A report commissioned by the Alzheimer's Disease International (ADI) and the Tsao Foundation estimates that "the number of those with dementia will increase in the Asia Pacific region from 13.7 million people in 2005 to 64.6 million by 2050."[13] Dementias are defined as the group of diseases that involve loss of short-term memory and other cognitive abilities, resulting in the inability to carry out daily functions. There is a lack of adequate resources and health policy initiatives in most Asian countries to deal with this threat, which is often viewed as an incurable disease.[14]

Community-based approaches to care-giving

Informal care-giving plays a critical role in approaches to community-based care. HelpAge Korea and the HelpAge International Network have developed a Home Care Programme that supports the training of a range of care-givers, including family members, active older people, and community volunteers. This programme is being implemented in the 10 ASEAN countries, and is providing an effective alternative to more formal and expensive care-giving facilities that are common in western countries[15].

Another experience in the HelpAge International Network is the mobilization of care-giving through Older People Associations (OPAs). Through a group of active volunteers in the associations, care-giving and accompaniment to clinics/hospitals is provided to the members of the OPA who are ill (in some cases, the OPA also contributes to the transportation and medical expenses). OPAs in Cambodia and China are active in this informal care-giving role, which protects the more vulnerable member of the older people in the community, especially those who are widows or widowers, or who don't have family members in the community.

Informal care-giving through community mechanisms has proven to be an effective service for vulnerable older people. These programmes, however, should complement the delivery of quality primary healthcare services and not replace them.

Good practices in the region

Both in China and Vietnam, the governments are vigorously supporting the development of social insurance schemes. Many of these are publicly subsidised schemes for poor people (including older people) to access services in the event of serious health conditions, and they are an effective way of ensuring the healthcare coverage for a broader numbers of the population[16].

In Vietnam, some medical universities and institutes in Vietnam, including Thai Nguyen Medical College, are revising the curriculum for medical doctors and nurses to include compulsory subjects on healthy ageing and geriatrics.

13 Dementia in the Asia Pacific Region: the epidemic is here" Access Economics, September 21, 2006.

14 There is a Consensus program that has been established to improve the quality of life for Asian people with dementia (QoLDEM). More information on this program and the Consensus Statement can be found at http://www.journals.cambridge.org

15 Additional information on the Home Care Programme can be found at http://www.helpage.org/Worldwide/AsiaPacific/Keyprojects/Promotinghomecare

16 For more information, see WHO (2005), Social Health Insurance: selected case studies from Asia and the Pacific, SEARO Regional Publication No. 42.

There are very few countries that include these topics in their academic curriculum for healthcare professionals.

The National University of Singapore (with Tsao Foundation as a key contributor) now offers a diploma in Geriatric Medicine. General practitioners receive training in geriatrics in order to increase the number of trained providers in this field in Singapore.

In Bireuen District of Aceh Province, Indonesia, the district government has issued a senior citizen's card for all older people. This card permits access to all levels of the health facilities in the district. This integration of services has reduced the time spent by older people in accessing services.

A European Commission project in 17 villages in 3 provinces in China (2003-2006), 3 medical universities trained 95 village health practitioners and 11 township doctors in healthy lifestyles and geriatric diseases. This training resulted in greater ability of primary healthcare practitioners to promote the health of older people.

Chapter 8: The impact of poor primary healthcare and chronic disease

As evidenced by the research conducted in the five countries, there is considerable need for greater knowledge of healthy ageing and the life course approach, as well as policies to support the access and quality of primary healthcare for older people. The case studies point out that failure to engage in health promotion and prevention leads to disability, financial hardship, emotional duress, and generally undermines the quality of life for older people.

There is ample evidence that the risks of developing chronic disease can be reduced and prevented through the adoption of healthy lifestyle habits, such as not smoking, greater physical activity, and improved diets. It is imperative that this knowledge be imparted to and by those who provide the essential healthcare to older people – the PHC service providers at the community level. It is also the PHC service providers that administer the screening for early disease detection, and thus play a critical role in the overall health and well-being of older people.

Failure by countries in Asia to adopt a more proactive approach to health promotion and prevention in relation to primary healthcare and chronic illnesses will surely lead to a loss of resources. In the United States, "the medical care costs of people with chronic diseases account for more than 75% of the nation's $1.4 trillion medical care costs."[17] Without policy measures to address PHC and chronic illnesses, resources spent on chronic illnesses will take away from other critical healthcare needs of the broader population. The WHO Report of the Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Development*, emphasizes that:

> The economic costs of avoidable disease, when taken together, are staggeringly high. Disease reduces annual incomes of society, the lifetime incomes of individuals, and prospects for economic growth. The losses are dozens of percent of GNP of the poorest countries each year, which translates into hundreds of billions of US dollars.[18]

In India, the estimated economic loss in national income in 2005 from heart disease stroke, stroke and diabetes is $9 billion, increasing to $54 billion in 2015.[19]

Furthermore, the commitments made at the Second United Nations World Assembly on Ageing in Madrid to ensure free and equitable access to primary healthcare services and to reduce by half the number of older people in poverty by 2015 are interlinked. Providing quality PHC services can improve health and reduce and prevent disabilities among older people, which decreases the amount of individual resources spent on maintaining health, thereby reducing the likelihood of becoming poor in old age.

17 US Centers for Disease Control and Prevention (2005), *Chronic Disease Overview*.

18 WHO (2001), *Macroeconomics and Health: Investing in Health for Development*, p. 22

19 Abegunde, D and Stanciole, A (2006), *An estimation of the economic impact of chronic noncommunicable diseases in selected countries*, p. 12.

Chapter 9: Summary of the key findings

'I don't want to be more of a burden to my family. My days are gone. What's the use of taking medicine?'

An older woman[20]
Bangladesh

The research teams found that the majority of the disadvantaged older participants in the study had low expectations of the access and quality of PHC services. Most experienced their conditions with a sense of fate, and were not aware of the interventions that could improve their health conditions. There were also socio-cultural factors, such as education and ethnicity, which lent to a mind-set of accepting existing conditions as part of their life struggle.

This section highlights additional findings from the country studies:

Health conditions of older people

- High number of older people who participated in the studies reported having at least one or more chronic diseases
- High number of older people reported that they have never had health screenings or had them very infrequently
- High number of older people report sporadic health monitoring and management even when diagnosed with chronic disease in the early stage of the disease; this increases the risk of complications and disability and associated financial difficulties (such as depletion of financial assets)
- High numbers of older people are unaware of healthy lifestyles and active ageing; the prevention, self-management, and treatment of chronic disease, especially hypertension and diabetes; and, desired more information from healthcare providers

Care-givers' perceptions

- Significant numbers of care-givers reported care-giving burdens, lack of knowledge on how to provide care and advice on healthy lifestyles, loss of income due to care-giving responsibilities, and high levels of stress

Older people's perceptions

- Perceptions among older people in relation to access to PHC are predominantly negative, however, urban older people were more satisfied with availability and accessibility of PHC services than rural older people
- In disaster areas, most older people reported that the PHC services deteriorated considerably after the disaster and have not recovered to pre-existing conditions

Health practitioners' perceptions

- Geriatric knowledge is limited among healthcare practitioners in both rural and urban areas, with knowledge in rural areas relatively poorer
- Facilities, medicine and equipment to treat chronic disease are poor in rural areas in the participating countries

20 HelpAge International, *Uncertainty Rules Our Lives: the situation of older people in Bangladesh*, p. 20.

Barriers to accessing primary healthcare services

- The primary barrier to accessing primary healthcare services in both rural and urban areas is financial cost
- The secondary barriers to accessing primary healthcare services in rural areas include: availability of trained healthcare providers, transportation and distance to healthcare facility, lack of knowledge of health services, and a desire not to leave the homestead unattended (due to danger of theft, child care, and crop or livestock responsibilities)
- The secondary barriers to accessing primary healthcare services in urban areas include: attitudes and services that are not age-friendly (for example, no respect, long waiting times, poor seating, etc.), poor physical environment, transportation, and lack of accompaniment to the facility for the older person

Appendix A: Methodology of the study

The locations of the research were identified by the country researchers, either on the basis of on-going project work or through their local knowledge of the disadvantaged communities; no income criteria was applied, and typically the older people were randomly selected to participate in the focus group discussions based upon membership in older people organizations in these disadvantaged communities. Care-givers were identified by older people participating in the focus group discussions, and healthcare workers were selected for interviews based upon the locations of the research.

The study is a qualitative data gathering, which was based on the following components.

- A background research was conducted through desk/documentary research on existing schemes and projections to health services for older people in terms of access, usage, cost and quality.
- A field research was conducted using three separate research methods (the research framework was pre-established to provide consistency among the research teams).
  - Focus group discussions with older people;
  - In-depth interviews with family care-givers and health service providers;
  - Case studies of older people with diabetes and stroke.
- The country research was documented in a report, detailing the background information, the study locations, the findings and the recommendations.

This consolidated report was prepared based on the data provided in the country reports, as well as inputs from the country research teams.

Appendix B: Country information

Cambodia	
Population data	14.1 million, total population 4.4% of population aged 60+
Disease profile (deaths)	35% Chronic disease 61% Communicable, maternal, and perinatal
Health financing	6.7 % of GDP on health
GDP per capita	US$ 6.1
Private expenditure on health	74%

Healthcare system:

In Cambodia, the healthcare system is made up of both public and private health service providers. The Ministry of Health is the national body that sets and enforces all policies and regulations with regard to the health sector. The public health system of Cambodia has undergone major reform over the last decade and key health indicators, still among the worst in the region, are improving. Indicators for HIV/AIDS, TB prevalence, child and maternal mortality rate, for example, have shown consistent reduction. For example, infant mortality rate in 2005 is 65 per 1,000 births compared to 95 per 1,000 births in 2000,[21] and the prevalence of HIV infection rate dropped to 1.9% in 2003.[22]

Many of these achievements were made possible by the increased commitment on the part of the government and the donor community to revitalise the once-dysfunctional public health system. A health strategy was put in place in 2002 to guide the investment and activities in the health sector for the next five years 2003-2007. In relation to health service for older people, the health strategy placed a priority emphasis on selected chronic and noncommunicable diseases among older people.[23]

Cambodia has been rebuilding its primary healthcare (PHC) system by incorporating both the traditional PHC delivery with newer innovations, such as the 'contracting-in' and 'contracting-out' approaches.[24] The health services available at this primary level are defined in the Minimum Package of Activities (MPA) to be delivered by the commune-based Health Centre (HC).[25] Each HC covers between 8,000 and 12,000 people. There has been no health service at this primary level that is directly focused on the needs of the older people. However, rural Cambodians prefer the "Paet Chhnoul" or local private health service provider for their PHC services, because of familiarity, accessibility and availability of medicine.

The PHC services as defined in MPA are accessible to older people since the HC is located in the middle of the coverage area to ensure that it is close to patients everywhere within that coverage area. Typically, the longest distance to the HC is no more than 5 kilometres. Because the health sector reform introduced subsidised drugs and small fees, the PHC services at the HC are now affordable to older people as well as the general population. A patient normally is required to purchase a health book which costs 1,000 riels (US$ .25) and can be used on three occasions. Once the book is used up, the patient can purchase a new one at the same price. The common drugs to treat headache, fever, and to improve intake of vitamin A and C are provided free of charge.

21 CDHS 2005, p. 18
22 WHO 2007.
23 HSSP 2002.
24 WHO (2002). *Primary health care review project: Region specific report*. Manila, Philippines. Details of 'contracting-in' and 'contracting-out' approaches can be found in Bushan, Keller, Schwartz (2002). Achieving the twin objectives of efficiency and equity: Contracting health services in Cambodia. ADB, Manila, Philippines.
25 MPA include 14 activities: general consultation, STD/AIDS, small surgery, test and cure malaria, vaccination, pre¬natal examination, birth spacing, normal birth delivery, post-delivery care, cure TB using DOTS, detect Hansen and referral service, provide vitamin A, detect malnutrition, and health education.

The current PHC services to older people is not adequate, particularly if older people suffer chronic illnesses. The PHC system is not designed to treat the chronic and complicated diseases. As far as the health education outreach activities are concerned, the priority attention is on promoting awareness of HIV/AIDS, TB, malaria, vaccination and immunisation of children and pregnancy care. The PHC system is integrated with the wider public health system. The HC works under the supervision of the Operational District's Referral Hospital (RH). The HC provides a referral service to patients who require sophisticated treatments to come to the Referral Hospital. The Referral Hospital also offers a referral service to patients whose treatment is only available in the large national hospitals in Phnom Penh.

India	
Population data	1,095 million, total population 7.6% of population aged 60+
Disease profile (deaths)	53% Chronic disease 36% Communicable, maternal, and perinatal
Health financing	5.0% of GDP on health
GDP per capita	US$ 5.4
Private expenditure on health	83%

Healthcare system:

The public healthcare system in India is a shared responsibility of the state, central and local governments; however, much of the delivery of the services are provided by the state governments, with the central government exercising how the funds are used through its constitutional fiscal authority[26]. The public healthcare system is seen as an important source of healthcare services due to the escalating costs in the private sector. And, the government has sought to strengthen the primary health care infrastructure through special assistance to regions with more health needs and encouraging the involvement of voluntary organizations[27].

There is an unquestionable lack of adequate healthcare services for older people in the country. The situation is in a very poor state in the rural and remote parts. Vast majority of older people in underserved areas are malnourished, live with a weak immunity and are prone to a wide range of infectious and chronic diseases. For example, there are an estimated 12 million blind people in the country. A majority of them are older people living in rural areas[28]. High prevalence rate of diseases such as Tuberculosis and Malaria among elderly is another fact that illustrates the complexity of situation. Concerned with the gravity of the situation, the Government of India came up with the National Policy for Older People (NPOP) in 1999 which strongly stresses on the needs of age-friendly healthcare interventions. Subsequently, efforts have been made by the government to mobilize resources and partner with various stakeholders. Nevertheless, desirable progress has not been made in this regard. Furthermore, geriatric healthcare remains an area of "lack-of-interest" among healthcare professionals and in medical schooling. India is also a unique country in terms of its diversities[29]. Every region of India is diverse with regard to ethnicities, languages, food-habits, religious practices, social culture and economic status. Hence, planning at national level becomes a difficult task. Characteristics of each region and associated disparities play a prominent role in developing effective, national level policies.

26 Das Gupta, M and Rani, M (2004), "India's Public Health System: How Well Does it Function at the National Level?"
27 WHO, Country Health Profile - India, See http://www.searo.who.int/EN/Section313/ Section1519 6810.htm
28 VISION 2020 India
29 India is a country of 35 states, 23 official languages and over 1,700 commonly used dialects.

Indonesia	
Population data	220 million, total population 7.6% of population aged 60+
Disease profile (deaths)	61% Chronic disease 29% Communicable, maternal, and perinatal
Health financing	2.8% of GDP on health
GDP per capita	US$ 11.1
Private expenditure on health	65%

Healthcare system:

There has been significant progress made in the past decade in Indonesia in terms of maternal and child health, immunizations and prevention and control of endemic diseases[30]. The indicators, such as the infant and under-five mortality rates have also improved, declining from 71 and 111 in 1986 to 33 and 45 per 1,000 live births in 2002[31]. This was in part due to the transfer of the delivery of public health services by the provincial and district health offices in 1987 and a reorganization in 1996; while, the Ministry of Health continues to maintain its policy and technical guidance role[32].

In Indonesia, the primary healthcare system has been developed through the establishment of primary health centres (puskesmas) at the district/city level down to the sub-district and village level. Primary healthcare at these centres is provided by a medical doctor, however, at the village level it is provided by a nurse. There are around 8,005 puskesmas in Indonesia[33]. Medical mobile units also provide services, especially to reach isolated areas. In the case of age-friendly primary healthcare (puskesmas santun usila), a team of one physician and two nurses are usually assigned to provide health services including home visits to the elderly. There are several ways older people pay for medical services (including medication):

1) pay-for-services (mostly in urban areas),
2) health insurance
3) poor family health insurance.

The two latter methods of payment are found mostly in rural areas. Referrals to secondary and tertiary health services are mainly through the primary health centre and licensed private practitioners.

30 WHO, Indonesia Country Health Country Profile
31 WHO, Indonesia Emergency Country Profile, 2004.
32 Ibid.
33 Presidential Report of the Indonesia Ministry of Health, 2007.

Singapore	
Population data	4.3 million, total population 10.6% of population aged 60+
Disease profile (deaths)	83% Chronic disease 12% Communicable, maternal, and perinatal
Health financing	3.7% of GDP on health
GDP per capita	US$ 321
Private expenditure on health	66%

Healthcare system:

Singapore's healthcare delivery system is a dual one, consisting of both public and private services: 80% of inpatient care is provided in 7 public hospitals, while 80% of primary healthcare is provided by 2,000 independently employed family physicians or general practitioners (GPs). There are currently 22 specialist geriatricians, and the bulk of primary care for the elderly is provided by private GPs (80%) while 20% is provided by 18 government run and subsidised polyclinics located across the island.

In the public sector, primary healthcare centres, or polyclinics, are run by teams of general practitioners, nurses, case managers or coordinators, and therapists. In the private sectors, general practitioners for the most part are in solo practice and do not employ trained nurses or other healthcare staff. Singapore also has home medical, home nursing and home hospice teams that provide primary care to homebound older people.

In addition, there are specialists located in public and private hospital outpatient clinics. These specialists do not act as primary care doctors, but treat the disease or syndrome for which the patient was referred to them. Many complicated or unstable diabetes and people with uncontrolled hypertension and complications from stroke are seen in specialist clinics, especially post hospitalisation. There is no formal coordination of care between specialists and primary care providers and one patient may see several specialists, who for the most part, do not coordinate care.

The philosophy of financing healthcare for the elderly in Singapore emphasises personal responsibility and family support, with the community and the government helping the indigent and the poor who cannot afford to pay for their basic healthcare needs. The Ministry of Health has also instituted a means test by which the fees for services are determined. People aged 65 and older pay subsidised rates (75% concession) for consultation, diagnostic tests and standard medications at specialist out-patient clinics in public hospitals and polyclinics. Non-formulary medications are not subsidised.

Vietnam	
Population data	83.1 million, total population 7.5% of population aged 60+
Disease profile (deaths)	66% Chronic disease 25% Communicable, maternal, and perinatal
Health financing	5.5% of GDP on health
GDP per capita	US$ 8.1
Private expenditure on health	73%

Healthcare System:

The healthcare sector in Vietnam is made up of both a public and private sector, where the public sector provides key services in terms of prevention, research and training. Most of the inpatient care is provided by the public sector, whereas the outpatient care is mainly provided by the private sector[34]. In the area of prevention, budget allocations are low, and the support of health insurance coverage is weak due to budget constraints.[35]

There is a large disparity in accessing healthcare services, depending on the region and the population group. For both those with and without health insurance, the main access to primary healthcare for older people is through a network of ward healthcare clinics and commune health stations, or through the district health care clinics and provincial hospitals. Those without health insurance must pay for services and medication themselves. However, if the older person has sufficient financial resources, they have more options to choose which type of services they want to use (local, district or provincial) and the type of doctor they would like for their healthcare services.

Older people in Vietnam are eligible to receive health insurance based upon four criteria: civil servants, war veterans and their families, the poor, and the voluntary contributors. However, in Vietnam, 66.6 percent of the persons aged 60 and older do not have access to health insurance.

The elderly with healthcare insurance often use district healthcare clinics for periodical health checks and prescriptions. When the older people need emergency services, they can also call a hotline and request at-home services where the doctor making the home visit can refer them to hospitals if needed.

34 WHO, Vietnam Country Health Information Profile, www.wpro.who.int/NR/rdonlyres/4A4ACA3A-239D-43A6-8407-47BEB8A6DCD1/0/40_Viet_Nam.pdf
35 Ibid.

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Resources

Age-friendly healthcare approaches for older people

Mainstreaming age-friendliness: A recapitulation of the collaborative effeorts between HelpAge International and the British Red Cross Society in Aceh, Indonesia, HelpAge International, December 2007

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http://www.helpage.org/Worldwide/AsiaPacific/Resources

Ageing in Africa
Ageing in Africa highlights the issues affecting older people in Africa, providing updates on HelpAge International's regional activities. It is produced 3 times/year.
http://www.helpage.org/Worldwide/Africa/Resources

‘The things I do to keep myself healthy are taking medicine, doing some exercise in the morning and not eating food that is too salty or sweet; I don’t have the money to go see the paet chhnoul (local private health service provider) regulary’

Older person, Cambodia

Primary healthcare for older people
A participatory study in 5 Asian countries

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Primary healthcare for older people is one example of how a society cares for vulnerable members. In this study in 5 Asian countries, researchers went to the field to ask the older people, care-givers, and the healthcare workers about the affordability and quality of primary healthcare services in their communities. The unanimous response was that a large proportion of older people did not access these services because of associated costs – both direct (medical fees) and indirect (transportation, poor services, excessive waiting times, etc.). Even when diagnosed with a chronic disease, older people reported sporadic health monitoring and management, which lends to greater health complications, disability in many cases, and added aggregate financial costs.

As population ages in Asia and greater demands are placed on healthcare systems due to chronic disease, more attention needs to be placed on preventative measures for older people to reduce both social and economic costs. This study provides recommendations under the main topics of the research to emphasize what countries and communities can do to improve the access and delivery of primary healthcare services, as well as examples of good practices in the region. Older people represent a valuable asset in society, and by improving the affordability and quality of primary healthcare services, societies can contribute to active and healthy ageing of both the current and future generations.

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