



# Older people's perceptions of health and wellbeing

*in rapidly ageing low- and middle-income countries*

**HelpAge**

**International**

**HelpAge International is a global network of organisations promoting the right of all older people to lead dignified, healthy and secure lives.**

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# Executive summary

This report presents the findings of an analysis of data collected by HelpAge International and its network members using HelpAge's Health Outcomes Tool. The tool is designed to collect data to better understand health and care in older age, and to measure the impact of HelpAge's health and care programmes. It was developed in response to the challenges posed by the lack of data on older people's health and care, particularly in low- and middle-income countries, and the resulting lack of understanding about how best to provide age, gender and disability sensitive services for older women and men. The tool was used between 2014 and 2017 in nine low- and middle-income countries across Africa, Asia and Latin America,<sup>1</sup> and gathered data from over 3,000 older people. The findings are presented here in the context of the current debate and evidence on older people's right to health.

As people age, their need for both health and social care are likely to become increasingly complex and interdependent. Ageing is associated with an increased risk of having more than one chronic medical condition at the same time ("multimorbidity"). As people age, they may require increased support with tasks of daily living to continue to do the things they want in the places they want to be. Recognising the complexities of health and care in older age and the importance of maintaining wellbeing and functional ability, HelpAge's work in health and care aims to increase access to services and support to enable older people to be able to keep doing the things they want to do, in the places they want to be, while enjoying the best possible quality of life, autonomy and independence.

This report explores three different areas in relation to ageing and health: older people's access to health services; availability of care and support; and the impact both health, and care and support services have on older people's health status, functional ability and wellbeing.

## Key findings

The key findings of this report resonate with and support current thinking on ageing and health. The data shows certain groups of older people are being left behind: the oldest old; those in rural areas; those with lowest levels of education; and those least able to meet their basic needs. Those older people who face the most significant barriers to accessing health services also struggle to access care and support, and to engage in self-care. As a result, these same older people rate their health, wellbeing and functional ability as poor.

### Access to health services

The data shows inequity in access to health services across the nine countries surveyed. Access to health services declines with age and is poorest among older women and men in rural areas. Affordability of health services is influenced by an older person's socio-economic status, with those least able to meet their basic needs, and those with the lowest educational levels, least able to afford health services.

### Access to care and support

The oldest old are the age group reporting the greatest challenge in accessing informal care and support. Respondents from the youngest age group also rated their access to care and support as poor. This contrasts with their rating of access to health services, and may be linked to a perception among family and community members that they do not yet need support, or that they should be able to manage and take care of themselves. Access to care and support is also influenced by socio-economic status, with those least able to meet their basic needs, and those with the lowest educational levels, least able to access support when they need it. When older women and men are able to access support, this is mostly provided by family members, and while self-care is reported by older people, it is more common among older women than men, and the extent of self-care reduces with age.

*Those older people who face the most significant barriers to accessing health services also struggle to access care and support, and to engage in self-care.*

1. Bolivia, Colombia, Ethiopia, India, Mozambique, the Philippines, Tanzania, Uganda and Zimbabwe.

## Impact on health, wellbeing and functional ability

Older people's feelings about their health, wellbeing and functional ability are influenced by age, gender, socio-economic status and location, with the oldest age groups, those in rural locations, and those with least ability to meet their basic needs reporting lowest levels of health, wellbeing and functional ability. Older women rate their health status more poorly than older men. With the same groups of older people reporting poorest access to both health services and care and support, and lowest perception of their health status, life satisfaction and functional ability, the data collected using the Health Outcomes Tool suggests a clear correlation between access to services and wellbeing.

## Recommendations

Based on the findings of HelpAge's data analysis, this report makes the following recommendations for governments and other service providers.

- **Develop health and care services and support that:**
  - respond to evidence;
  - target those being left behind;
  - take into account older people's needs and preferences;
  - recognise that people in older age have a diverse range of needs.
- **Include older people in all efforts to achieve universal health coverage and respond to the specific income insecurity faced in older age to ensure:**
  - health services are affordable and older people do not face financial hardship in accessing them;
  - essential health service packages include the services most needed to address the health challenges common in older age.
- **Develop and strengthen health and care systems to provide integrated care** that is person-centred, responding holistically to older people's needs.
- **Support older people's ability to self-care**, providing older people with the information and education they need to make changes to their own lives to support healthy ageing.
- **Ensure data collected on older people's health and care is fully disaggregated** by age, sex, disability, socio-economic status and location to provide a strengthened evidence base and enable greater targeting of interventions.



# Health in an ageing world

Population ageing is a major 21st century trend<sup>2</sup> in all regions of the world and is a result of significant achievements in human development – in particular improvements in health, which have led to increasing longevity and declining mortality rates.<sup>3</sup> In 2015, there were 900 million people worldwide aged 60 and over, comprising 12 per cent of the global population. While the Asia-Pacific region has the world's largest number of people aged 60 and over (508 million), Europe is the region with the largest percentage of its population in this age group (24 per cent, or 177 million). Although Africa has fewer older people, numbers are projected to rise from 64 million in 2015 to 105 million by 2030, with this region set to experience the most rapid pace of ageing between now and 2100. As public health gains continue to advance and health systems are strengthened, global life expectancy will continue to increase. Between 2015 and 2030, the number of people worldwide aged 60 and over is projected to grow by more than half, reaching 1.4 billion in 2030 – over 16 per cent of the global population.

Many of these older people will have complex health and care needs. These are often associated with having more than one chronic condition at the same time, accompanied by a need for increased support with daily tasks. Older people, particularly in low- and middle-income countries (LMICs) face multiple barriers in accessing health services. Systems designed to diagnose and cure acute (short-term) conditions are ill equipped to respond to the chronic (longer term) illnesses more common in older age. In addition, many LMICs lack any formal system for delivering long-term care and support. The challenges of simultaneously providing complex health and social care services put people with complex needs at risk of living a greater proportion of their older age in poorer health, with higher rates of disability and lower levels of wellbeing.

In response to these issues, in 2015 the World Health Organization (WHO) published the *World Report on Ageing and Health*. The report provides a new conceptual framework to support healthy ageing, defined as “the process of maintaining the functional ability that enables wellbeing in older age”.<sup>4</sup> This emphasis on functional ability<sup>5</sup> is an important step away from a sole focus on trying to improve health in older age by addressing specific diseases, and towards supporting older people to remain able to do the things they value. The WHO report highlights the importance of person-centred, integrated and holistic care to address the complexity of health and care needs in older age.

## Lack of data is a barrier to healthy ageing

There is a significant lack of data about health, wellbeing and functional ability in older age, particularly in LMICs. Many population-based surveys have upper age limits, for example 49 or 64 years. Demographic and Health Surveys (DHS) normally exclude women aged 50 and over, and men aged 55 or 60 and over. The WHO STEPwise Approach to Surveillance (STEPS) survey, assessing risk factors for non-communicable diseases (NCDs), suggests the inclusion of people up to age 64 or 69 only. Excluding people over these ages limits available data on older people. Moreover, when data is collected, it is not always adequately disaggregated by sex, age, and disability, to reflect heterogeneity in older age. Instead, data on people aged 50 and over is often presented as a single cohort, (“50+”) – misleadingly suggesting that all people age in the same way and have the same needs for health and care services and support. This report shows that this is not the case.

The lack of data on older people's health poses many challenges. It leads to poor understanding and recognition of health and care needs in older age, and a lack of evidence to inform policy development, and the design, delivery and evaluation of services.

*Data on people aged 50 and over is often presented as a single cohort, (“50+”) – misleadingly suggesting that all people age in the same way and have the same needs for health and care services and support.*

2. United Nations, *Monitoring of population programmes, focusing on changing population age structures and sustainable development, in the context of the full implementation of the Programme of Action of the International Conference on Population and Development Report of the Secretary-General*. E/CN.9/2017/3, New York, United Nations, 2017

3. United Nations Department of Economic and Social Affairs, *World Economic and Social Survey 2007: Development in an Ageing World*, New York, United Nations, 2007

4. World Health Organization, *World report on ageing and health*, Geneva, World Health Organization, 2015

5. The health-related attributes that enable people to be and to do what they have reason to value; it is made up of the intrinsic capacity of the individual, relevant environmental characteristics and the interactions between the individual and these characteristics.

# The Health Outcomes Tool

In response to these data challenges, HelpAge developed its Health Outcomes Tool to collect data to better understand health and care in older age. The Health Outcomes Tool is a community-based survey tool on healthy ageing for use in LMICs. It was designed with the primary purpose of measuring the impact of HelpAge's health and care programmes, to inform how best to support health and functional ability in older age and to provide an evidence base to support advocacy and influencing work. The tool assesses older people's health and wellbeing, as they perceive it, focusing on individuals' own view of their health status and wellbeing and the services and support available to them. By collecting data on these issues, the tool can be used alongside other biomarker data, to better understand the current health status and functional ability of older women and men and how this changes over time.

The tool was used between 2014 and 2017 in nine countries across Africa, Asia and Latin America,<sup>6</sup> with data gathered from over 3,000 older people. The findings are presented here against the backdrop of current debate and evidence on the right to health of older people.

## Health Outcomes Tool domains

The Health Outcomes Tool comprises interrelated domains that measure factors affecting older people's health. The tool includes a set of self-reported questions and the "sitting-to-standing test" – a functionality test that assesses a person's ability to stand from a sitting position using the following assessment options:

- Able to stand without support of arms and stabilise independently.
- Able to stand on own on first try using support of arms.
- Able to stand using support of arms after trying several times.
- Needs minimal aid to stand or stabilise (the person needs to be supported a little to stand).
- Needs moderate or maximal assistance to stand (the person needs to be supported a lot to stand).
- Not able to perform test.

This combination of self-reporting and the sitting-to-standing test allows for triangulation of data, with the sitting-to-standing test providing a more objective measure to complement the subjective questions. The domains in the tool are as follows:

- Demographic data: age, gender, disability, economic status, education, household composition and location (see Box 1 for information on the collection of data on economic status).
- General health perception: self-rated health and life satisfaction.
- Functionality: ability to conduct social and work activities<sup>7</sup> mobility, support provided, and objective sitting to standing test.
- Health services: respondents' perceptions of access, quality and affordability.
- Self-care: who is considered responsible for health, extent of self-care and action(s) taken.

The data collected under each domain is analysed individually and in relation to each other to provide an holistic view of an older person's self-perceived health, wellbeing, and functional ability.

*The tool assesses older people's health and wellbeing, as they perceive it, focusing on individuals' own view of their health status and wellbeing and the services and support available to them.*

6. Bolivia, Colombia, Ethiopia, India, Mozambique, the Philippines, Tanzania, Uganda and Zimbabwe.

7. Changes to the functional ability questions: Data on perceived functional ability was collected by asking people to score themselves, reflecting on their ability to conduct a range of tasks and activities such as bathing, dressing, maintaining continence, and farming. During the development of the Health Outcomes Tool, a number of different approaches to measure functional ability were tested. In this report the analysis of functional ability includes only the most recent approach and is therefore based on 1,078 respondents from India, the Philippines, Tanzania and Uganda.

Many of the questions in the health outcomes tool use a scale from 0 to 100. In all data collections, a visualisation of the scale (such as a 1-metre ruler) is used in the interview. For each of the questions using this scale, respondents are asked to mark their score on the scale. The 0-100 scale methodology serves to transfer people's perceptions into quantitative data for analysis and to capture change over time. Zero represents the worst situation or opinion and 100 represents the best.

### **Box 1: Note on data collection**

While most versions of the tool included a question about the respondent's ability to meet basic needs, this data was collected in different ways in different countries. It was either collected by asking respondents to report whether or not they can meet basic needs (responses included either "yes/no", or "yes/no/sometimes"); or through a series of questions asking the respondent whether or not they are able to pay for the following: house, food, safe drinking water, and maintaining good hygiene.

The data from these two different ways of asking this question was combined during data analysis. When a respondent indicated that they were not able to pay for any of the listed basic needs this was coded as "No". When a respondent indicated being able to pay for all the listed basic needs, this was coded as "Yes". When the respondent indicated that there was at least one basic need that they were not able to pay for, this was coded as "Sometimes/Partly".

In some cases, data was not collected on ability to meet basic need but rather on self-reported poverty levels. Data on poverty levels is available for 2,492 respondents.



Jonas Wresch/HelpAge International

## **Sampling method**

The data analysed in this report is baseline data collected from programmes implemented by HelpAge and its partners. The sampling methodology used depended on the nature of the programme being evaluated and the target population reached. For example, data was collected in the Philippines to better understand the differences in healthy ageing between older people in rural and urban areas and differences in the health status of older people covered by PhilHealth (the government health insurance scheme) and those not covered.

In Ethiopia, Mozambique, Tanzania and Zimbabwe, sampling was done in the programme areas of a three-year HelpAge health and care programme, and included people aged 50 and over. In India, data was collected from people aged 60 and over from five villages in the Jodhpur district of Rajasthan. Snowball sampling<sup>8</sup> was used in two sites in Colombia and three sites in Bolivia. The Philippines sample included people aged 60 and over, based on age distributions in the 2010 Census of Population and Housing<sup>9</sup> in two provinces (Metro Manila and Quezon Province). In Metro Manila, the sample comprised equal numbers of programme beneficiaries and non-beneficiaries as a control group.

None of the countries used an upper age limit in their sampling approach. The sample in each of the nine countries was small, ranging from 94 in Colombia to 522 in India, and not nationally representative. Samples were calculated to be representative of the target population of the programme being implemented. In some cases, such as Uganda, this meant a higher proportion of women in the sample to reflect the focus of the programme (see Figure 1 for countries, domains, and respondent profiles).

## Data analysis and limitations

The data analysis presented in this report aims to provide a detailed picture of the health and wellbeing of older people in the communities in the nine countries surveyed. The analysis explores emerging patterns, trends, similarities and differences in the data, disaggregated by age, gender, socio-economic factors and location.

The analysis has a number of limitations. It has not been possible to disaggregate the data by disability status. In line with HelpAge's approach to sex, age and disability disaggregated data, the Washington Group questions<sup>10</sup> on disability have been included in the Health Outcomes Tool. This inclusion was agreed in a later version of the tool, so in the baseline dataset only one of the nine countries to implement the tool so far has collected data on disability using these questions. A disability analysis is therefore not possible for this report but will be in future analyses as more rounds of data collection are conducted.

There are a limited number of locations, varying sample sizes and methodologies between the countries. The phased nature of the data collection, over a two-and-a-half-year period, saw some modifications to the tool. As a result, some analyses and conclusions drawn are based on a subset of the overall dataset.

Given these issues and the fact that the datasets are not nationally representative, the aim of this analysis and report is not to draw concrete conclusions on older people's health throughout the nine countries, or to make comparisons between countries. The aim is rather to comment on emerging patterns and trends, and to consider these trends within the context of broader discussions of, and research on, ageing and health in LMICs.

Despite these limitations, in the absence of data on older people's health and care in many of the contexts in which the tool has been used, the data collected provides a useful snapshot of older people's perceived health, wellbeing, functional ability, and their perceptions of the services and support available to them. The baseline data analysed in this report provides a comparator for assessing changes over time, with the Health Outcomes Tool designed to be conducted on a recurring basis with the same older people. Further data collection in new communities and contexts will help to develop an evidence base on older people's health and care in LMICs.

The online dashboard that accompanies this report<sup>11</sup> provides an opportunity for users to interact with the data collected and draw out further analyses – for example, to filter responses by certain age groups, gender etc, and to look at particular indicators in relation to others.

*The analysis explores emerging patterns, trends, similarities and differences in the data, disaggregated by age, gender, socio-economic factors and location.*

8. Snowball sampling is where research participants recruit other participants for a test or study in a location where participants are hard to recruit.

9. Philippine Statistics Authority, 2012

10. The Washington Group questions are designed to identify, in a census or survey format, people with a disability. The questions ask whether people have difficulty performing basic universal activities (walking, seeing, hearing, cognition, self-care and communication) and were originally designed for use with the general population. The focus on functioning and the brevity of the tool mean that it can be rapidly and easily deployed in a variety of settings. The questions should not be used in isolation but in conjunction with other measurement tools, for example as part of a larger survey ([www.washingtongroup-disability.com/washington-group-question-sets/short-set-of-disability-questions/](http://www.washingtongroup-disability.com/washington-group-question-sets/short-set-of-disability-questions/)).

11. The dashboard can be found at [https://public.tableau.com/profile/helpage.international#!/vizhome/HelpAgeHealthyAgeingGlobalAnalysis\\_0/PublishedStory](https://public.tableau.com/profile/helpage.international#!/vizhome/HelpAgeHealthyAgeingGlobalAnalysis_0/PublishedStory).

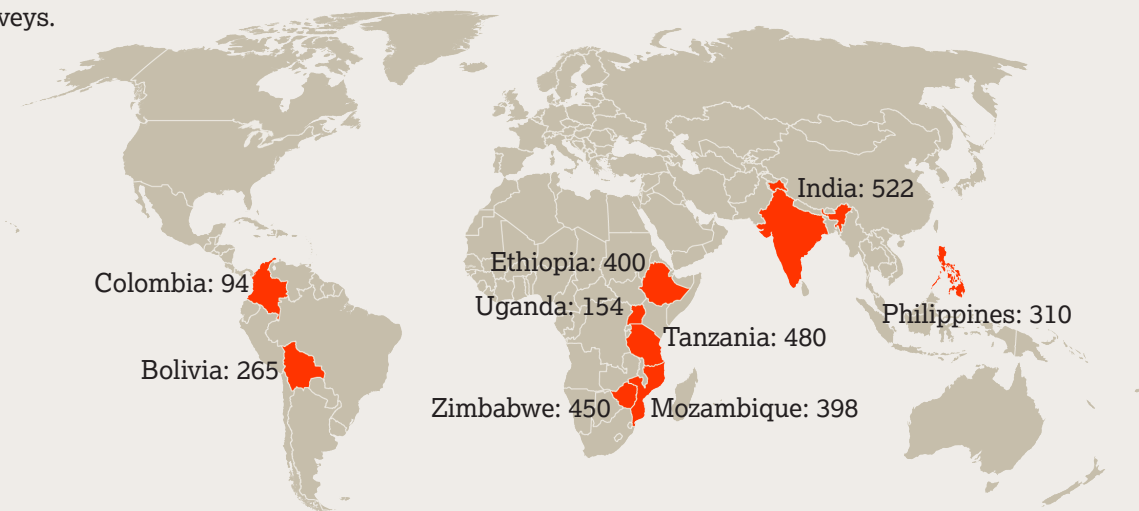
12. In Ethiopia, data was only collected in urban settings, while India and Mozambique data was only collected in rural settings. The sample from peri-urban settings is the smallest and comes from Uganda and the Philippines.



# Figure 1: Countries, domains, and respondent profiles

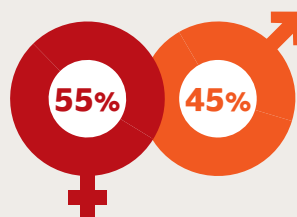
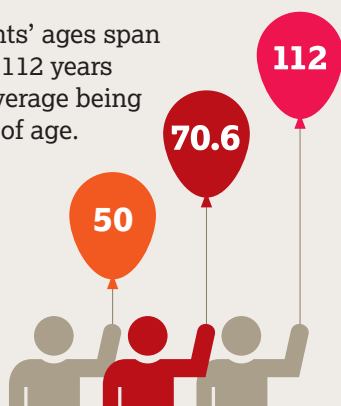
## Global spread

Over 3,000 respondents from around the world took part in the surveys.



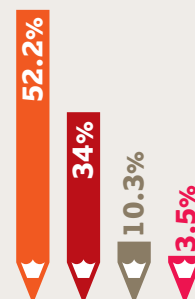
## Age

Respondents' ages span from 50 to 112 with the average being 70.6 years of age.



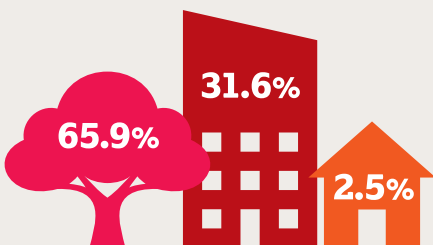
## Gender

55% of respondents are female and 45% male.



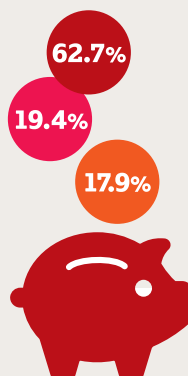
## Education

52.2% of respondents have no education or pre-primary only, 34% have primary, 10.3% secondary or vocational and 3.5% have higher education.



## Location<sup>12</sup>

65.9% of respondents live in a rural setting, 31.6% urban and 2.5% peri-urban.



## Economic status

19.4% of respondents are able to meet basic needs, 62.7% are sometimes/partly able and 17.9% are not able.

# What the data tells us about ageing and health

Using the data collected with the Health Outcomes Tool, this report explores three issues in relation to ageing and health. The first section looks at older people's barriers in accessing health and care services and support in the communities surveyed, focusing on ease of access, affordability and quality. The second section explores how health, wellbeing and functional ability in older age can be supported, both through care and support received from others and older people's ability to self-care. The final section presents data on health status, life satisfaction and functional ability, highlighting the potential impacts of access to services and appropriate care and support for older people.

*This skills gap in the health workforce is a critical challenge in ensuring older people's right to health is met.*

## Barriers to access

Evidence shows that older people face multiple challenges in accessing health and care services and support. Poor physical access to clinics and hospitals, limited mobility due to increasing levels of disability in older age, the prohibitive cost of services, a lack of awareness of health conditions and of available health and social care services, as well as discrimination based on age, gender and disability, are all barriers faced by older people. In many LMICs, health systems have not adequately kept up with the changing needs of ageing populations. Many of these systems were designed to address a different burden of disease, focusing on diagnosing and curing acute conditions and leaving them less-well equipped to respond to and manage longer term, chronic conditions commonly experienced in older age.

The complex nature of health in older age demands an integrated and person-centred approach whereby health workers dealing with different issues work together to provide holistic care. However, the current, disease-focused structure of many health systems means this integration and coordination rarely happens adequately. Health workers also lack the knowledge and skills needed to be able to provide appropriate, targeted care to older people. Many current training approaches and curricula do not include specialisms such as geriatrics and gerontology,<sup>13</sup> and often lack even basic training on the types of health issues faced in older age. A survey of 36 countries found that 27 per cent of medical schools did not conduct any training in geriatric medicine.<sup>14</sup> A 2012 study found that of 40 countries in Africa, 35 had no formal undergraduate training for medical students in geriatrics and 33 reported no national postgraduate training scheme in geriatrics.<sup>15</sup> This skills gap in the health workforce is a critical challenge in ensuring older people's right to health is met.

Data collected using the Health Outcomes Tool provides some insight into older people's access to health services and support at community level, and the factors that might influence this. The tool has a broad focus on access, looking at three issues: ease of access; affordability; and quality. The following questions in the Health Outcomes Tool use the 0-100 scale to capture older people's perceptions in relation to access:

- In your opinion, how easy or difficult is it to access health care? 0 represents poor access. 100 represents very good access.
- During the past three months, how affordable was health care? 0 represents poor affordability. 100 represents very good affordability.
- Over the past three months, how would you rate the quality of the health care services in your community? 0 represents poor quality. 100 represents very good quality.

Data on access was collected in the communities in all nine countries where the Health Outcomes Tool has been implemented, with a total sample size of 2,982 to 3,065, depending on the question.

13. Geriatrics is the branch of medicine specialising in the health and illnesses of older age and their appropriate care and services, while gerontology is the study of the social, psychological and biological aspects of ageing.

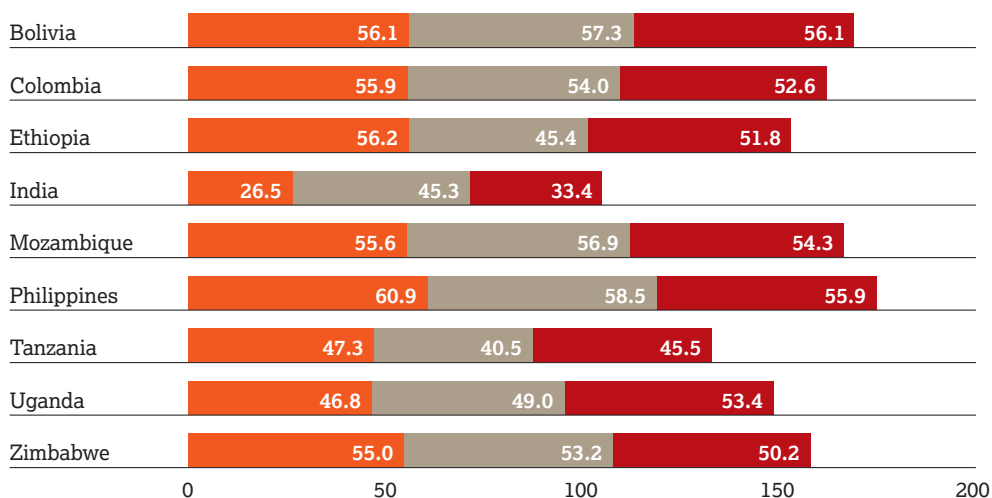
14. Keller I, Makipaa A, Kalenscher T, Kalache A, *Global survey on geriatrics in the medical curriculum*, Geneva, World Health Organization, 2002, [www.who.int/ageing/projects/en/alc\\_global\\_survey\\_tegeme.pdf](http://www.who.int/ageing/projects/en/alc_global_survey_tegeme.pdf)


15. Dotchin C L et al, 'Geriatric medicine: services and training in Africa', *Age Ageing* Jan;42(1), 2013, 124-8, doi: 10.1093/ageing/afs119, Epub 2012 Sep 30, [www.ncbi.nlm.nih.gov/pubmed/23027519](http://www.ncbi.nlm.nih.gov/pubmed/23027519)


In response to the three access questions, average scores were clustered around the mid-point. The average score for ease of access across the nine countries was 48.5, ranging from 33.3 in India to 56.1 in Bolivia. For affordability the average score was 49.4, ranging from 40.5 in Tanzania to 57.3 in Bolivia; and for quality, 49.9 with a range of 26.5 in India to 60.9 in the Philippines (see Figure 2).


Responses to all three access questions were influenced by age, with decreasing scores recorded as the respondent's age increased,<sup>16</sup> suggesting **people face increasing difficulty accessing health services and support as they get older** (see Figure 3). The most marked decline with age was seen in response to the question on ease of access. The data collected suggests gender is less of a factor where access is concerned, with less significant differences in scores between women and men than between different age groups. A small difference was recorded in older women and men's perceptions of ease of access (49.3 for women and 47.5 for men) and quality (50.6 for women and 47.9 for men).

**Figure 2: Older people's perceived access to health services, by country**

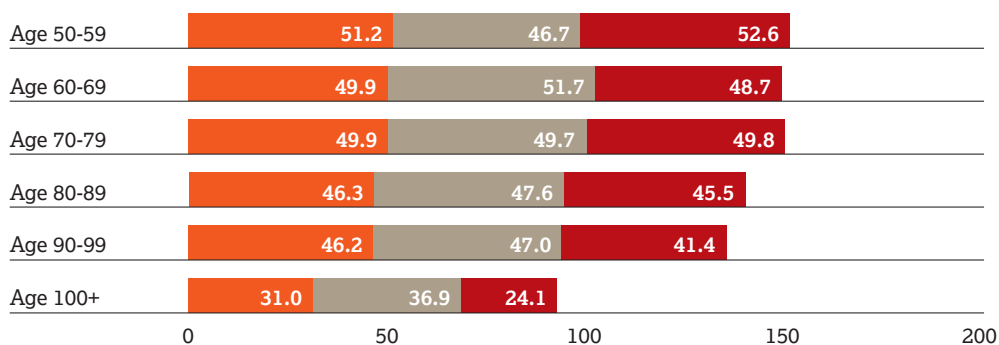


 In your opinion or experience, how easy or difficult is it to access health care?

 During the past 3 months, how affordable was health care?

 Over the past 3 months, how would you rate the quality of the health care services existing in your community?

**Figure 3: Older people's perceived access to health services, by age**



A more in-depth analysis of the three separate questions on access, looking at linkages with some of the other factors collected using the Health Outcomes Tool, indicates some of the potential reasons for older people's difficulty in accessing health services.

<sup>16</sup> Ease of access: 50-59 (52.9), 60-69 (48.6), 70-79 (49.7), 80-89 (45.4), 90-99 (41.4), and 100+ (24.1)

Affordability: 50-59 to 60-69 from 50-59 (46.5), 60-69 (51.6), 70-79 (49.6), 80-89 (47.5), 90-99 (47.4), 100+ (33.8)

Quality: 50-59 (52.1), 60-69 (50.0), 70-79 (49.7), 80-89 (46.5), 90-99 (47.3), 100+ (28.6)

## Ease of access

The ease of access question in the Health Outcomes Tool relates to people's perception of the physical accessibility of services. Physical access can be influenced by a range of issues, including distance to a health facility, the physical environment at the facility and a person's level of mobility. In its 2015 *World Report on Ageing and Health*, WHO highlighted the importance of health services being located as close as possible to where people live, so that services are more easily accessible at community level. This is particularly important for older people for whom the need to travel long distances to access health and care services and support may place those services out of reach.<sup>17</sup>

Over recent years significant emphasis has been placed on strengthening primary health care (PHC) in LMICs, and as a result some gains have been made. Case studies of the PHC systems in Ethiopia, Tanzania and Uganda published in 2017 by WHO and the Alliance for Health Policy and Systems Research highlight achievements made in reducing distances to health facilities and increasing accessibility, but state that more needs to be done. The Ethiopia case study highlights improved access to health services at community level through the rapid expansion of health centres and health posts, and the implementation of the government's Health Extension Programme, including the introduction of Health Extension Workers.<sup>18</sup>

The Uganda case study states that 72 per cent of the population live within 5km of a health centre that provides PHC, with anecdotal evidence suggesting the distance may be lower (3km).<sup>19</sup> However, distribution remains inequitable, with access still a challenge in sparsely populated, rural, and hard-to-reach areas. Evidence from other countries also suggests access may be more challenging for those in rural areas. A HelpAge study in rural Tanzania<sup>20</sup> found that older people's access is substantially affected by distance, and the availability and cost of transport. The most common means of reaching health facilities for older people is walking, with journeys taking up to four hours, and the average distance to a health facility, 8km. In Mozambique and Zimbabwe, the average distance to a facility is 10km.<sup>21</sup> In Ethiopia, 25 per cent of urban and 68 per cent of rural households have no health facilities within walking distance.<sup>22</sup> With older people facing these distances to health facilities and a lack of available transport, for many, services remain out of reach.

The Health Outcomes Tool data on respondents' location – urban, peri-urban (in some instances) and rural – suggests **ongoing barriers to access for older people in rural areas. Respondents in urban and peri-urban areas reported better access to health services**, scoring 52.0 and 53.1 respectively, than those in rural areas, scoring 46.7. Older people in a peri-urban area in the Philippines scored their access to health 71.7. The average score for ease of access was 48.5. In India, where data was only collected in rural areas, the mean score was significantly lower than the average, at 33.3. This data and broader evidence and analysis on access to PHC, and the extent to which this access is equitable across the population and in geographic terms, suggests **greater effort is needed to increase access in rural areas, particularly for older people.**

Data collected using the Health Outcomes Tool also shows the potential influence of educational level on access to health services. Ease of access average scores were 45.8 for those with no education or only pre-primary level education, rising to 57.5 for older people with higher education. This data suggests **greater effort is needed to ensure older people with lower levels of education are included in, and specifically targeted by, health education and awareness programmes, to ensure they have the information they need to encourage improved health-seeking behaviour.** The findings from the Health Outcomes Tool analysis indicate **lack of information and awareness as an important barrier to access in older age.** This may be exacerbated by lower literacy levels among older women and men in comparison with other age groups<sup>23</sup> and fewer health education and promotion campaigns targeted at older people.

*With older people facing these distances to health facilities and a lack of available transport, for many, services remain out of reach.*

17. World Health Organization, *World Report on Ageing and Health*, Geneva, World Health Organization, 2015

18. World Health Organization, *Primary health care systems (PRIMASYS): case study from Ethiopia*, Geneva, World Health Organization, 2017

19. World Health Organization, *Primary health care systems (PRIMASYS): case study from Uganda*, Geneva, World Health Organization, 2017

20. HelpAge International, *Learning with older people about their transport and mobility problems in rural Tanzania*, London, HelpAge International, 2015

21. HelpAge International, *Cash transfers and older people's access to healthcare, a multi country study in Ethiopia, Mozambique, Tanzania and Uganda*, London, HelpAge International, 2017

22. World Health Organization, *Country Profile, Ethiopia*, 2016

23. UNESCO, UNESCO Institute for Statistics, Sustainable Development Goals data (education), <http://data.uis.unesco.org/index.aspx?queryid=166>

## Affordability

Older people face high levels of income insecurity and in LMICs access to social pensions is poor. In these countries only around 25 per cent of older people have access to a social pension.<sup>24</sup> Of the nine countries where HelpAge has implemented the Health Outcomes Tool, five<sup>25</sup> have some form of social pension and the remaining four currently have no scheme in place. In the five countries with a social pension there are issues of adequacy and coverage. The pension schemes in these countries do not form a significant percentage of an older person's income, ranging from 2.2 per cent in India to 15.5 per cent in Mozambique. In Mozambique, where adequacy is highest, coverage is only 24 per cent of older people (aged 60 and over), and as with three of the other countries with a social pension,<sup>26</sup> the schemes are means tested rather than universal.<sup>27</sup>

Affordable health services are also often lacking. In many LMICs health service supply is poor in terms of availability, accessibility, affordability, and adequacy. Government expenditure on health is often low, ranging in the nine countries studied from US\$26 per capita in Ethiopia in 2014, to US\$569 per capita in Colombia. Colombia had a significantly higher spend on health than the other countries, with six of the nine spending less than US\$100 per capita.<sup>28</sup> As a result of low government expenditure, out-of-pocket expenditure on health makes up a significant proportion of total health expenditure in the countries where the Health Outcomes Tool has been implemented. This ranges from 9.5 per cent in Mozambique to 62.4 per cent in India (see Table 1).

**Table 1: Out-of-pocket expenditure in countries studied**

Country	Percentage of total expenditure on health
Bolivia	23.1%
Colombia	15.4%
Ethiopia	32.3%
India	62.4%
Mozambique	9.5%
Philippines	53.7%
Tanzania	23.2%
Uganda	41.0%
Zimbabwe	35.9%

Source: World Bank, Health, Nutrition and Population Statistics, 2014  
<http://databank.worldbank.org/data/reports.aspx?source=Health%20Nutrition%20and%20Population%20Statistics#>

In this context of income insecurity in older age and poor investment in health systems, the cost of health services and support is prohibitive for many older people. Data collected through the Health Outcomes Tool gives an indication of the **importance of an older person's socio-economic situation in relation to their ability to afford health services**. The scores provided by older people on affordability, compared with their ability to meet their basic needs, confirm a **link between affordability and socio-economic status**. Those who answered they were unable to provide for their basic needs scored health service affordability at 46.4 out of 100 compared with a score of 52.1 by those who state they are able to provide for their basic needs – a mean difference of 5.8.

24. International Labour Organisation 2014  
World Social Protection Report 2014-15

25. Bolivia, Colombia, India, Mozambique and the Philippines

26. Colombia, India and the Philippines

27. HelpAge International Pension Watch website  
[www.pension-watch.net/pensions/country-fact-file](http://www.pension-watch.net/pensions/country-fact-file)

28. World Bank, *Health, Nutrition and Population Statistics*, Washington DC, World Bank, 2014

Differences are also seen in the affordability scores for those with different levels of education, which may influence their work and income status. The mean score for affordability for older people with no education or pre-primary education only was 47.7 compared with 58.5 for those with higher education. The Health Outcomes Tool data also points to the **link between ability to work and affordability of services, with a moderate relationship between the two.**

Analysis of the Health Outcomes Tool data supports the assumption that **cost is a key barrier to access for older people, and that those with the highest levels of income insecurity and the lowest levels of education are most significantly affected.** This points to the **need for increased efforts to ensure health services are affordable to all, and highlights the importance of commitments to, and efforts towards, the achievement of universal health coverage (UHC), and its core tenet that all people must have access to the health services they need without suffering financial hardship.**

## Quality

Data collected against the third question addressing access – quality of services – also showed some interesting patterns and trends. “Quality” is a core component of the right to health<sup>29</sup> and WHO defines quality of care as “the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes”. To achieve this, a number of criteria must be met, including health services being equitable – this means delivering health care that does not differ in quality according to personal characteristics such as gender, race, ethnicity, geographical location or socio-economic status.<sup>30</sup>

In terms of equity, an analysis of scores on the quality of health services by the demographic characteristics of the sample suggests **further efforts are needed to ensure all older people in the communities surveyed have access to quality health services.** As stated above, age was shown to have an impact on access to health services with **increasing age having a negative effect across all three access questions.** On average, older people scored the quality of health services available in their communities at 49.9 out of 100. A significant variation in the score was seen when analysed by age. People aged 50-59, the youngest age group, scored their health services 51.2 for quality, compared with 31.0 for the oldest group, constituting a difference of 20.2 between the youngest and oldest. Gender appeared to be less of a factor, but differences were seen in the scores provided by women and men across the nine countries, with women scoring the quality of health services at 50.6 compared to 47.9 for men.

Looking at socio-economic status, a small difference was seen between older people’s ability to provide for their basic needs and their perception of the quality of health services. Scores for quality were also influenced by educational level, with those with no education or only pre-primary level education scoring the quality of services 45.0, compared to 53.9 for older people with higher education. Geographical location was also a factor, with **respondents in urban areas reporting higher scores for quality of health services than those in peri-urban and rural areas**, 56.0, 48.3 and 46.6 respectively.

Data collected using the Health Outcomes Tool suggests challenges with equity in access to health services across three of the characteristics highlighted by WHO, and most significantly by age, a characteristic not included in WHO’s definition of quality of health care.

Considering the definition of quality as the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes, the Health Outcomes Tool data has been analysed to look for a potential link between perception of quality and self-reported health and life satisfaction. The data across the nine countries shows a positive correlation between both quality and health status ( $r = .204$ ) and quality and life satisfaction ( $r = .352$ ). This highlights the **importance of older people having access to quality health services within their communities for their health and wellbeing.**

29. World Health Organization, *Human rights and health factsheet*, Geneva, World Health Organization, 2017, [www.who.int/mediacentre/factsheets/fs323/en/](http://www.who.int/mediacentre/factsheets/fs323/en/)

30. World Health Organization, Definition of quality health care, available at [www.who.int/maternal\\_child\\_adolescent/topics/quality-of-care/definition/en/](http://www.who.int/maternal_child_adolescent/topics/quality-of-care/definition/en/)

## Care and support for older people

In many situations, the inadequacy or absence of health services, and the barriers faced by older people mean that older women and men must be effectively self-reliant in looking after their health and care needs. The challenges in accessing formal health services highlighted in the previous section have resulted in a dependence on informal systems of care provided largely at the home and community levels.

Access to formal health services and care and support that are coordinated and integrated (providing a continuum of care) is critical for older people as their health needs become more complex and their need for support with daily tasks simultaneously grows. In low- and middle-income countries, the inadequacy of the health system and the lack of any formal system for the provision of care and support mean that the responsibility for older people's health and care needs often rests with family and community members. These caregivers are often unrecognised, undervalued, unpaid and under-supported. The cost of this responsibility for families can be acute in financial terms, but also in relation to the caregivers' own health and emotional wellbeing. This can have an impact on the quality of care provided. Older women are particularly affected, taking on the caregiving responsibility for spouses, other family members and peers while often needing care themselves.

Estimates of the number of older people in need of long-term care, defined by WHO as "the activities undertaken by others to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity,"<sup>31</sup> are thought to be significant under-representations due to the assumptions employed in generating the estimates. However, available data suggests that around half of all people aged 65 to 74 in LMICs are care dependent, with the estimates increasing with age.<sup>32</sup>

Recognising the current dependence on informal and family care, and the importance of self-care, the Health Outcomes Tool includes questions aimed at providing information on older people's living circumstances, their access to support, and their understanding of and ability to self-care. The following questions were asked of older people:

- To what extent are you able to access support when you need it? 0 represents not at all; 100 represents very much.
- How much do you take care of your own health? 0 represents not at all; 100 represents very much.
- Who do you think is primarily responsible for your health? (Multiple choice question: myself; my household; health workers; others).
- What kind of action(s) do you do to take care of your health? (Multiple choice question: I seek treatment; I do physical exercise; I have a balanced diet; I have my blood pressure taken; I adhere to my treatment;<sup>33</sup> none of the above).

Four countries collected this data on support and self-care: India, the Philippines, Tanzania and Uganda, with a total sample size of 1,078.

*These caregivers are often unrecognised, undervalued, unpaid and under-supported.*

31. World Health Organization, *World Report on Ageing and Health*, Geneva, World Health Organization, 2015

32. World Health Organization, *World Report on Ageing and Health*, Geneva, World Health Organization, 2015

33. Only given as an option in the Tanzania survey.

## Access to support

The average score on the extent to which older people were able to access support when needed was 53.2 across the four countries, ranging from 45.3 in Uganda to 61.8 in the Philippines. When analysing the data by the different characteristics, trends begin to emerge. An analysis against the age of respondents shows **the youngest and oldest people in the sample are least likely to be able to access support when they need it**. This could be due to a perception from family and community members that those in the younger age group do not yet need support, or that they should be able to take care of themselves. **For those in the oldest age cohorts, who are least able to access support, this could be due to their isolation and invisibility within their communities and their weakened support networks, with peers and family members having already died (see Table 2). The lack of support available to the oldest old is particularly concerning given their increased need for support**, which will be explored in the next section of this report.

*The lack of support available to the oldest old is particularly concerning given their increased need for support.*

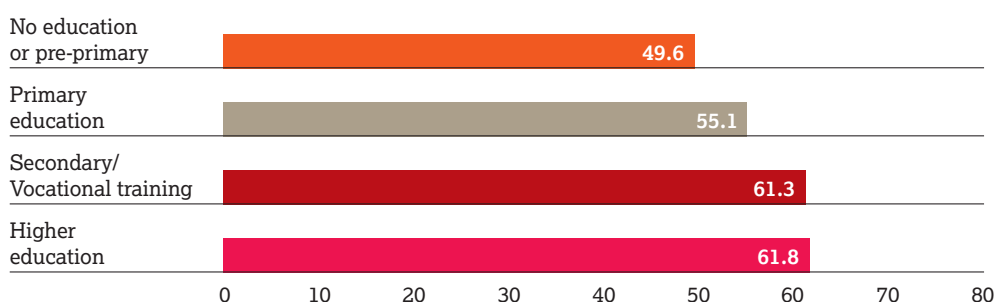
**Table 2: Access to support, by age**

Age group	Mean
50-59	44.9%
60-69	55.7%
70-79	52.4%
80-89	50.6%
90-99	44.4%
100+	28.8%
	<b>Average 53.2%</b>

Similar to the data collected on access to health services, gender appears to be less of a factor than age in relation to older people's ability to access support when they need it. There was not a significant difference between the scores provided by older women and men.

Other characteristics presented more interesting findings. Data collected in India, the Philippines, Tanzania and Uganda suggests **socio-economic status influences the extent to which older people are able to access support when they need it**. There was a significant difference in the extent of support provided according to respondents' ability to meet basic needs. Scores on access to support decreased from an average of 59.6 from those who answered they were able to meet their basic needs, to 49.8 from those unable to meet their needs. There was also a **significant difference in the extent of support provided by level of education, with those with higher levels of education more able to access support (see Figure 4)**.

**Figure 4: Access to support, by education level**





Geographical location also appears to be a factor, with those in urban areas more likely to be able to access support than those in rural communities (see Table 3).

**Table 3: Access to support, by location**

Location	Mean
Urban	60.3%
Peri-urban	49.0%
Rural	52.5%
	<b>Average 53.5%</b>

In addition to the question on the extent to which an older person is able to access support when they need it, the Health Outcomes Tool also asks who provides this support. The data collected highlights **the current informal nature of support, with 81 per cent of respondents saying they receive support from their families and 18 per cent from friends, neighbours and community members.**

The data collected on access to support largely mirrors data on access to health services, when analysed against different demographic characteristics. The data suggests that **older people who are least able to access formal health services also struggle to access informal support.** This poses a significant challenge in meeting the needs of specific groups of older people, but also presents something of an opportunity. The importance of both health services, and care and support services, in meeting the complex health and care needs of older people in LMICs is clear. The fact that certain groups of older people appear to struggle to access both types of service and support points to the importance of integrated care. Strengthening the approach to integrated care through a focus on both the health and care and support systems simultaneously could provide opportunities to address the dual challenges of access to both health services and care and support.

## Self-care

WHO defines self-care as “activities carried out by individuals to promote, maintain, treat and care for themselves, as well as to engage in making decisions about their health”.<sup>34</sup> Self-care starts with people taking responsibility for their own health on a daily and longer-term basis. It is about the choices individuals can make to support their own health and wellbeing, including staying active, eating healthily, reducing risky behaviours such as drinking alcohol and smoking, and seeking health services and support when needed. Recognising the role self-care can play in improving health and increasing longevity, and its continued importance as people age, the questions on self-care were included in the Health Outcomes Tool to enable better understanding of the extent to which older people are practicing self-care and the form this takes.

The first self-care question explored who respondents felt was primarily responsible for their health, with multiple choice options available to rank. Table 4 summarises the responses and demonstrates a **comprehensive understanding among older people in the communities surveyed of their personal responsibility for their own health.** Ninety per cent of older people also felt that members of their household were responsible for their health.

34. World Health Organization, *World Report on Ageing and Health*, Geneva, World Health Organization, 2015

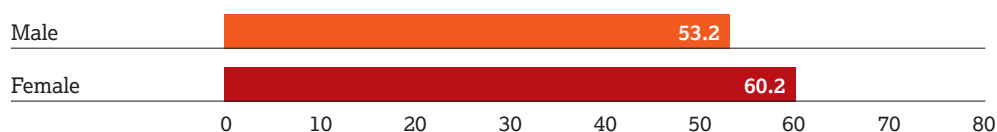
This is an interesting finding when considered in relation to responses to the question on who provides support to older people when it is needed. Although 81 per cent of older people said they received support from their family members, the majority of this support came from family members outside the older person's household, with only two per cent saying they received support from family members within their home.

**Table 4: Who is primarily responsible for your health?**

Who	Yes	No	Total	% Yes
Myself	807	25	832	97%
My household	570	64	634	90%
Health workers	175	139	314	56%
Others	24	133	157	15%

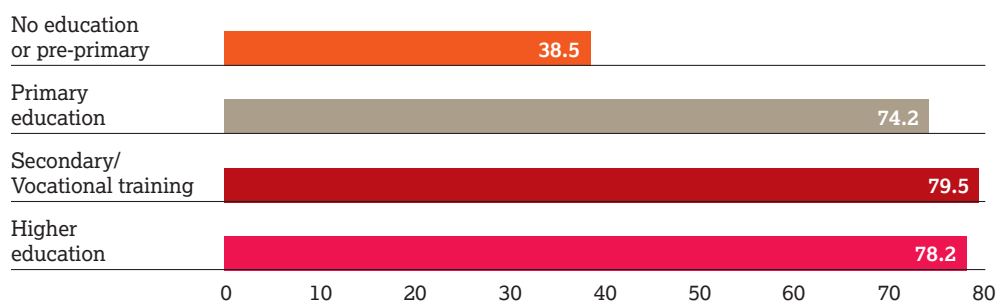
The second self-care question explored the extent to which older people engage in self-care, scored using the 0-100 scale. The average score across the four countries where the self-care questions were asked was 57, ranging from 37 in India to 79.6 in Uganda. **The extent to which older people engaged in self-care differed by both age and gender, with extent of self-care decreasing as age increased.**<sup>35</sup> Older women scored their level of self-care more highly than older men, with a difference in average score of 7 (see Figure 5).

**Figure 5: Extent of self-care, by gender**



Significant differences were seen in the extent of self-care practiced when disaggregated by both ability to meet basic needs and level of education. **Older people who were able to meet their basic needs were more likely to engage in self-care** than those who were unable, scoring 69.7 and 55.7 respectively. Similarly, **older people with higher levels of education were also more engaged in self-care.** Those with higher-level education scored the extent of their self-care 78.2 compared to 38.5 among those with no education or pre-primary level education only (see Figure 6).

**Figure 6: Extent of self-care, by education level**



35. 50-59 = 79.9, 60-69 = 59.4, 70-79 = 56.1, 80-89 = 49.5, 90-99 = 36.8, 100+ = 55.0

Following the pattern emerging from both the access to health services and support questions, geographic location also appears to be a factor in relation to extent of self-care. **Older people in rural communities appear to be less engaged with self-care than those in peri-urban and urban areas**, with average scores of 49.7, 82.2 and 79.4.

The final question in the self-care section of the Health Outcomes Tool explores the actions taken by older people to manage their own health. The most common action taken across the four countries was eating healthily, with 59 per cent of the sample highlighting this action. This was followed by seeking health services. Fifty-seven per cent of the sample responded that they sought health services on a regular basis. Forty-five per cent engaged in physical exercise and 33 per cent reported having their blood pressure taken.

Looking at data from the four different countries, similarities and some significant differences can be seen. Eating a healthy diet appears to be a more common self-care activity in the communities surveyed in India and the Philippines, while seeking health services was given higher priority in Tanzania and Uganda. Blood pressure monitoring was a less common action, with the exception of Uganda. This result may have been influenced by the community-level intervention supported by HelpAge, which included a focus on hypertension (see Table 5). These differences point to the **need for further research on self-care and the importance of interventions being evidence-based and targeted appropriately to the local context**.

*The oldest age groups, and those with the least ability to meet their basic needs, lowest levels of education and living in rural communities are least able to practice self-care.*

**Table 5: Types of self-care action taken at the community level**

<b>% of people reporting "Yes"</b>	<b>India</b>	<b>Philippines</b>	<b>Tanzania</b>	<b>Uganda</b>
I look for health services regularly	30.5%	73.1%	90.0%	92.1%
I do physical exercise	15.9%	77.3%	70.0%	60.3%
I eat healthily	43.5%	90.3%	39.0%	63.6%
I have my blood pressure taken	4.8%	66.2%	26.0%	68.9%
<b>Average</b>	<b>23.7%</b>	<b>76.7%</b>	<b>56.3%</b>	<b>71.2%</b>

As with the analyses presented in the previous sections on access and support, the same groups of older people appear to be being left behind in relation to ability to self-care. The oldest age groups, and those with the least ability to meet their basic needs, lowest levels of education and living in rural communities are least able to practice self-care.

An interesting finding from the analysis of the data on self-care is the low level of self-care being practiced in the communities in India. The average score on extent of self-care was 37, compared to the average across the four countries of 57. Older people in the communities surveyed in India also scored their access to health services, both in terms of ease of access and quality, significantly below the average, and had a lower than average score on the extent to which support was accessible when needed. Further targeted research is needed to understand the potential low levels of care across formal health services, informal support, and self-care, in the communities in India. The potential impact of older people's perceived poor access to services and support will be explored in the following section of the report, looking at the impact of access on health status, functional ability and life satisfaction.

## The impact on health, wellbeing and functional ability

The goal of HelpAge's health and care work is to ensure the right of older women and men to the best attainable health and care services, and supporting wellbeing right through to the end of life. Recognising the complexities of health and care in older age and the importance of maintaining wellbeing and functional ability, HelpAge's work in health and care aims to increase access to services and support to enable older people to be able to keep doing the things they want to do, in the places they want to be, while enjoying the best possible quality of life and independence.

The Health Outcomes Tool was designed to provide evidence from the community level on the extent to which activities supporting access to services and support could impact older people's health, functional ability and wellbeing. To measure this, the following questions on health status and life satisfaction were asked using the 0-100 scale, with 0 representing the worst score and 100 the best:

- Overall, how would you rate your health during the past three months?
- Overall, how satisfied have you felt with your life during the past three months?

The question on health status was asked in all nine countries. Data on life satisfaction was collected in four countries – India, the Philippines, Tanzania and Uganda.

As stated earlier, during the testing of the Health Outcomes Tool, different approaches to the measurement of functional ability have been used. The analysis in this report is based on data collected in India, the Philippines, Tanzania and Uganda, using the most recent set of questions on functional ability, all of which use the 0-100 scale:

- During the past three months, how would you rate your ability to independently conduct your usual social and/or daily activities (e.g. feeding, bathing, getting dressed, walking in and around the house, going to the toilet, maintaining continence, managing medications)?
- During the past 3 months, how would you rate your ability to independently conduct your work activities (e.g. farming, preparing meals, fetching water/firewood, washing clothes, shopping/going to the market, managing own finances, home repair and maintenance)?
- How far can you move around without anyone helping you?



In addition to the self-report questions on functional ability, the objective sitting-to-standing test was also used.

This section of the report explores the data collected on health status, life satisfaction and functional ability, looking at how scores for each vary by age, gender, socio-economic status and location, and at the potential influence of access to health services and support on older people's perceived health status, life satisfaction and functional ability.

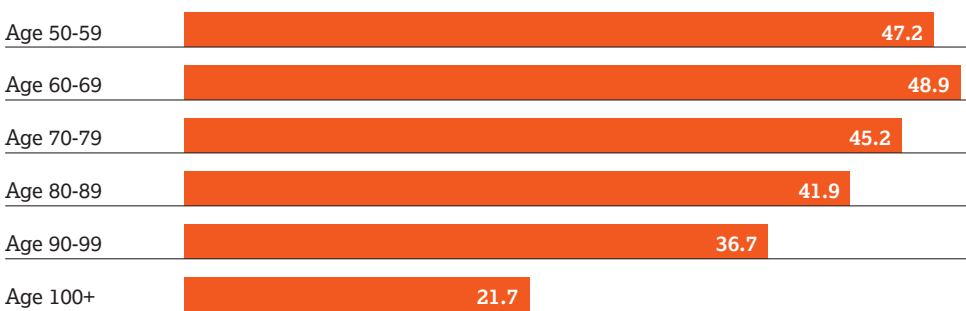
*Older people most able to meet their basic needs reported significantly higher health status scores.*

## How older people score their health, life satisfaction and functional ability

The findings of an analysis of the data on self-reported health status, life satisfaction and functional ability by demographic characteristics suggests a continuing trend described in the previous sections of this report. **Across all three impact-measures, scores appear to be influenced by age, socio-economic status and location**, with gender emerging as potentially less significant.

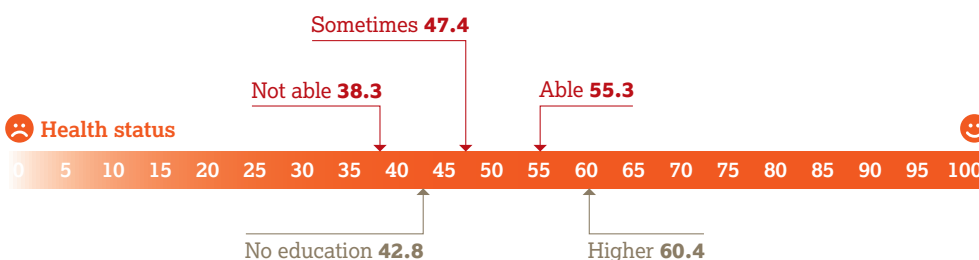
The average score for health status across the nine countries was 46.2, ranging from 40.6 in Bolivia to 56.3 in the Philippines. As with the access, support and self-care indicators, the scores for health status declined as age increased. The difference in scores was significant from the age of 60 upwards, decreasing from 48.9 among those aged 60-69 to a low of 21.7 in the oldest age group, 100 and over (see Figure 7).

**Figure 7: Self-reported health during the past three months, by age**



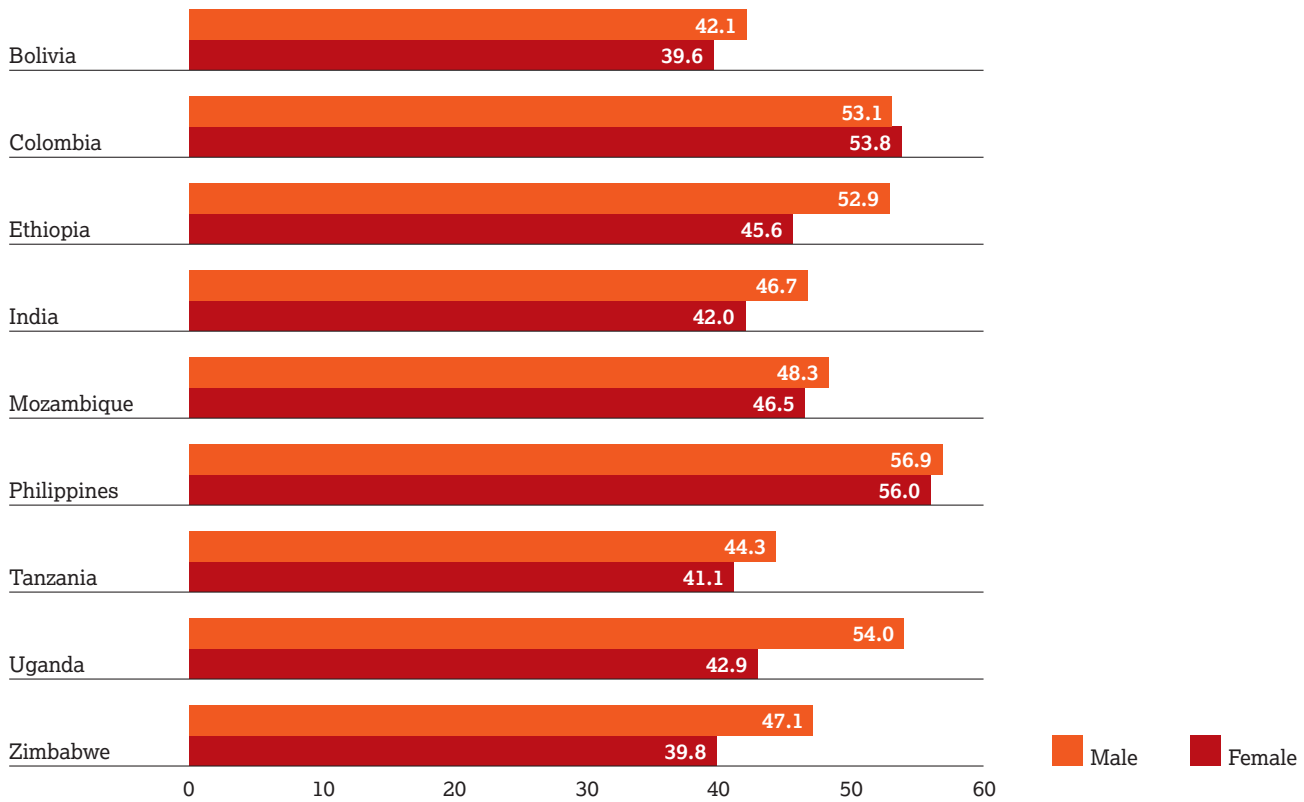
**Older people most able to meet their basic needs reported significantly higher health status scores than those who are sometimes or partly able to meet their basic needs, or not able to meet their basic needs, 55.3, 47.4 and 38.3 respectively.** Similarly, older people with higher educational levels also report higher health status, ranging from an average score of 60.4 among respondents with higher education to 42.8 among those with no education or pre-primary education only. **Health status scores also appear to be influenced by an older person's location with those in urban areas reporting higher health status, at 48.9, than those in rural communities, 44.9 (see Figure 8).**

**Figure 8: Health status score by ability to meet basic needs (above) and education level (below)**



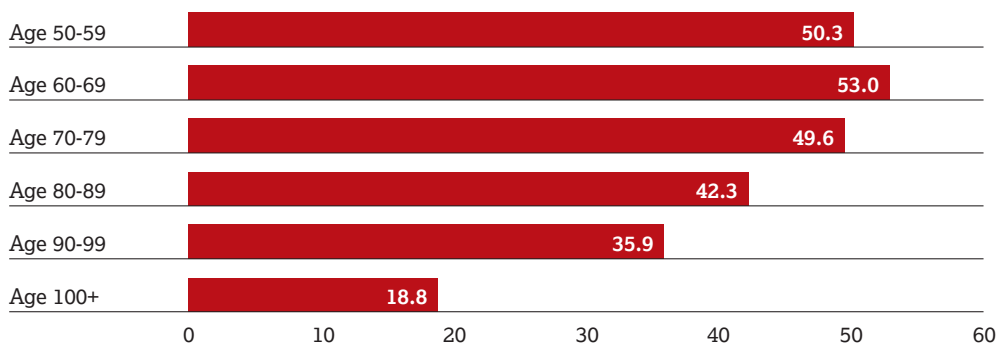
In relation to self-reported health status, **gender appears to be significant, with older women reporting a significantly lower average score than older men across all countries except Colombia.** The data from Zimbabwe, Ethiopia, and Uganda show large disparities in older women and men's scores (see Figure 9).

**Figure 9: Self-reported health during past three months, by country and gender**



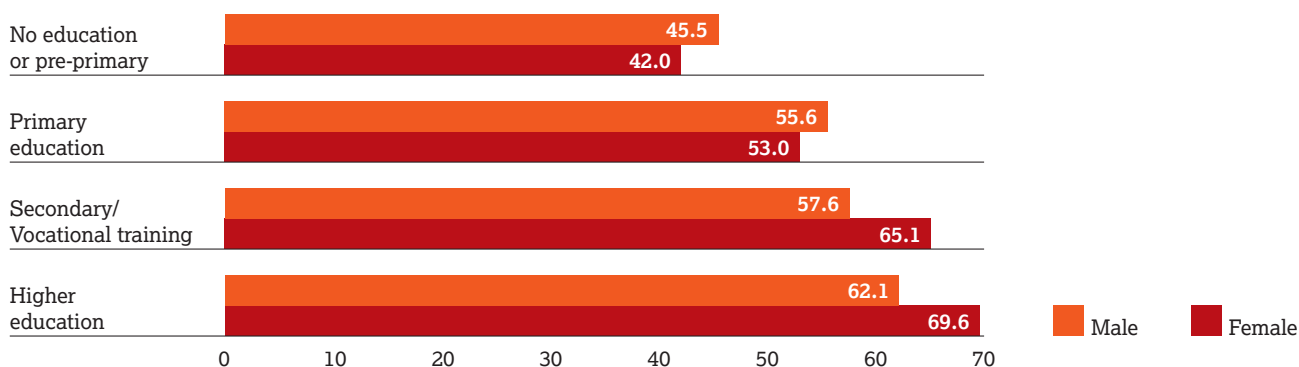
The average score for life satisfaction across the four countries where this data was collected is 50.0, ranging from 44.6 in India to 62.8 in the Philippines. Largely the same patterns emerge as with health status. Scores for life satisfaction decrease with increasing age from an average score of 50.3 for those aged 50-59 to an average of 35.9 for people aged 90-99 and a low of 18.8 for people aged 100 and over (see Figure 10).

**Figure 10: Life satisfaction during the past three months, by age**



Life satisfaction scores varied considerably depending on whether the respondents were able to meet their basic needs. Those most able to meet their basic needs scored their life satisfaction 57.4 compared with 48.5 among those only sometimes or partly able to meet their basic needs, and 46.2 among those not able to meet their basic needs. The scores followed the same pattern for educational level. Older people with no education or pre-primary level education only scored their life satisfaction 43.6, significantly lower than those with primary level education, 54.0, secondary or vocational level, 61.7 and higher education, 65.5 (see Figure 11).

**Figure 11: Life satisfaction during the past three months, by education level and gender**



Unlike health status, there was no statistically significant difference in life satisfaction scores between older women and men, suggesting gender is less of a factor.

The average scores for the different questions used to measure functional ability differed significantly, with the score for ability to carry out work activities lower than those for ability to do daily activities and level of mobility:

- Ability to carry out daily and social activities = 63.1.
- Ability to carry out work activities = 50.2.
- Mobility, extent that they are able to move around = 66.6.

Average scores for each of the functional ability measures decreased with increasing age. The scores for daily activities ranged from an average of 84.5 for people aged 50-59 to 41.3 for those aged 100 and over. For the same age groups, the scores for work activities ranged from 69.9 to 38.3 and mobility from 89.2 to 47.5.

The moderate negative relationship between all the functional ability measures and age demonstrated by the scores suggest that **functional ability declines with age**.

There was a significant difference between daily activities, work activities, and mobility when analysed by ability to meet basic needs. For example, the average scores for daily activities decreased from 69.8 among those who are able to meet their basic needs to 54.5 for those who are not. The same trend was also present according to educational levels. The largest differences in scores was seen in response to the question on ability to conduct work activities, with older people with no education or pre-primary level education only scoring their functional ability in this regard at 37.3 compared to 64.7 among those with higher education.

The average scores for daily activities, work activities, and mobility were significantly different between rural areas and peri-urban or urban areas. Work activities had the biggest difference in scores, with higher scores in both urban and peri-urban areas, 64.4 and 58.4 respectively, compared to 45.5 in rural areas. As with life satisfaction, there was not a significant difference between the functional ability scores of older women and men.

The sitting-to-standing test was included in the Health Outcomes Tool to provide an objective measure of functional ability and to allow for triangulation of data with the self-reported functional ability questions. While the results differed between countries, a negative correlation was seen with age and a positive correlation with educational level, ability to meet basic needs, and location, supporting the scores from the self-reported functional ability measures.

### **The impact of access to health services, care and support on health status, life satisfaction and functional ability**

WHO's *World Report on Ageing and Health* highlights the gaps in health and long-term care systems, services and support in LMICs and the impact these gaps can have on older people's health and functional ability. The report states that ensuring access to appropriate health and care services and support will be essential in overcoming the challenges faced by older people and the current inequalities experienced in health and wellbeing.

This section of the Health Outcomes Tool report looks at what the data collected by HelpAge says about the impact of access, or lack thereof, to health services and care and support on older people's health status, life satisfaction and functional ability. Existing evidence demonstrates that poor access to services has a detrimental effect on health status across the population. A 2016 report by the OECD explores the impact of universal health coverage on health outcomes.<sup>36</sup> The report finds that for a selection of OECD countries and emerging economies (Brazil, China, Colombia, Costa Rica, India, Indonesia and Russia) there is a clear positive association between the elements of UHC and life expectancy, meaning good access to health helps increase life expectancy. Increased spending on health (a proxy for health coverage) has played a significant role in increasing life expectancy in the countries studied over recent decades. Increased health spending contributed to about one year of observed life expectancy gains.

While there is little, if any, research into the specific impact of access to health services on the outcomes among the older population, the OECD report supports the narrative that progress made through global health initiatives has contributed to population ageing, and goes on to stress that this demographic change makes improving access to health and care services and support through UHC all the more important if the health and care needs of older people are to be adequately met.

Given the relationship between access to health services, informal support and extent of self-care, with age, socio-economic status and location (and the mirrored relationship between those same demographic characteristics and health status, life satisfaction and functional ability), it is likely that **access to services and support, both formal and informal, will have an influence on older people's health, functional ability and wellbeing.** An analysis of the data collected using the Health Outcomes Tool supports this assumption.

A positive correlation was seen between all three elements of access to health services – ease of access, affordability and quality – and older people's self-perceived health status.<sup>37</sup> Similarly, there was a positive correlation between the three elements of access and life satisfaction<sup>38</sup> and functional ability.<sup>39</sup> Ability to do daily activities also had moderate relationships with access to health services and affordability of health services.<sup>40</sup>

The data also suggests **an older person's ability to self-care also has an impact on their health status, life satisfaction and functional ability.** A positive correlation was seen between the extent of self-care and all three impact measures – health status, life satisfaction, and functional ability.<sup>41</sup> The extent of self-care being practiced also had a strong relationship with ability to do work activities, and ability to do daily activities – two of the measures of functional ability – and life satisfaction, and a moderate relationship with health status.<sup>42</sup> **The data therefore supports the call for increased access to health and care services and support that are better targeted at the needs of older people, and provides evidence of the impact that this increased access can have on older people's health status, wellbeing and functional ability.**

In line with the WHO's healthy ageing agenda, which takes a more holistic approach, putting maintenance of functional ability and wellbeing at the heart of efforts to support health in older age, the **data suggests a link between health status, life satisfaction and functional ability. There is a strong positive relationship between health status and life satisfaction.**<sup>43</sup> However, the analysis does not explain which of the two measures influences the other. Functional ability is also important with all three measures – the ability to do both daily<sup>44</sup> and work activities,<sup>45</sup> and mobility<sup>46</sup> – having a clear relationship with both health status and life satisfaction.

These trends emerging from the Health Outcomes Tool data point to the **importance of a holistic and integrated approach to health and care in older age, that moves away from a sole focus on the presence or absence of disease and the resultant health outcomes, to considering healthy ageing in its broader sense.**

*The data therefore supports the call for increased access to health and care services and support that are better targeted at the needs of older people.*

36. Pearson M, Colombo F, Murakami Y, James C, Universal health coverage and health outcomes, Paris, OECD, [www.oecd.org/els/health-systems/Universal-Health-Coverage-and-Health-Outcomes-OECD-G7-Health-Ministerial-2016.pdf](http://www.oecd.org/els/health-systems/Universal-Health-Coverage-and-Health-Outcomes-OECD-G7-Health-Ministerial-2016.pdf)

37. Access – r = .226; affordability – r = .258; quality – r = .204

38. Access – r = .359; affordability – r = .429; quality – r = .352

39. Access – r = .349; affordability – r = .352; quality – r = .288

40. Access – r = .35; affordability – r = .35

41. Health status – r = .330; life satisfaction – r = .402; functional ability – r = .458

42. Work activities – r = .54; daily activities – r = .46; life satisfaction – r = .40; health status – r = .33

43. R = .691

44. Ability to do daily activities had moderate relationships with life satisfaction (r = .48), health status (r = .46)

45. Ability to do work activities had moderate relationships with life satisfaction (r = .51), health status (r = .48)

46. Mobility had strong relationships with ability to do daily activities (r = .67), ability to do work activities (r = .56), and moderate relationships with health status (r = .42), life satisfaction (r = .38)



# Conclusions

This report reveals the patterns and trends emerging from data collected with older people in communities across nine LMICs using the HelpAge Health Outcomes Tool. These patterns and trends are discussed within the broader context of the challenges older people face in accessing health and care services and support.

Data from across the nine countries gives an indication of how some of the well-documented barriers to health services for older people affect their access and paints a picture of who is being left behind. Across the range of indicators in the Health Outcome Tool, the data suggests older people's access to services and support is being influenced by demographic characteristics – with the oldest old, those with the least ability to meet their basic needs and the lowest levels of education, and those in rural areas consistently reporting the greatest challenges in accessing services and support.

The data analysis suggests gender is less of a factor than other characteristics, at least in relation to some indicators. This is a surprising finding and warrants further analysis to determine potential reasons, and whether those reasons be related to methodological issues. In India, baseline data collection identified some challenges with collecting data from older women (see Box 2). Analysis of a subsequent round of data collection may reveal different trends in relation to gender.

The data shows the significant implications for those being left behind. It suggests a clear relationship between access to health services, informal care and support, and ability to self-care, health status, life satisfaction and functional ability. Those with the poorest access are feeling the greatest impact in terms of their wellbeing. With access to both formal health services and care and support having an impact on health status, life satisfaction and functional ability, and the same older people facing challenges in accessing both types of service, the data collected using the health Outcomes Tool supports the **call for more integrated and holistic care**. In LMICs whose health systems are not fit for purpose in an ageing world, and which lack any formal care and support system, **a joined up approach to reform is needed**. These countries have the opportunity to establish and strengthen both care and health systems that work better together to provide the integrated and holistic care needed to ensure older people are supported to enjoy the best possible health, wellbeing and functional ability right through to the end of life.

## Box 2: Hearing the stories of older women in India

Ageing and the health of older people is largely neglected in India, with older women's health given least attention of all. Through its health interventions, HelpAge network member GRAVIS has seen that this lack of focus begins with older women themselves, who will often not talk about, or take sufficient action in relation to, their health and care needs. The experience of implementing the Health Outcomes Tool supported this observation, with older women more hesitant to engage in discussion of their health and functional ability and more likely to be influenced in their responses by the views of their family members.

GRAVIS has worked to address this challenge through gender-sensitive training of its interviewers and ensuring older women are always interviewed by a woman. More time is given to interviews with older women in anticipation of needing to spend longer gaining their trust and confidence, and for a more gradual opening up of discussion about their health. Through engaging with the Health Outcomes Tool process, it is hoped that the older women respondents will begin to think about, and engage with, their own health and wellbeing in a more meaningful way, and will gain greater benefit from GRAVIS' health interventions in their communities.

After the second round of data collection interviewers began to share anecdotal evidence of the women being more open and forthcoming during their second interview. Subsequent rounds of data collection will look to explore this issue further.

# Policy recommendations

The following table summarises the main findings highlighted in this report and makes recommendations for what needs to change to ensure older people's right to health and care is promoted and protected.

Finding	Policy recommendation
<b>Headline findings</b>	
<p>Certain groups of older people are being left behind in health and care, with the oldest old, those in rural areas, those least able to meet their basic needs, and those with the lowest levels of education least able to access formal health systems and struggling to access care and support. These same groups rate their health, wellbeing and functional ability poorly</p>	<p>Ministries of Health and other service providers should develop targeted health and care services and support that respond to evidence on who is being left behind in specific local contexts, that take into account older people's needs and preferences, and that recognise the heterogeneity in older age</p>
<p>Older people who are least able to access formal health systems struggle to access care and support</p>	<p>Governments and other stakeholders should develop and strengthen long-term care systems and health systems to provide integrated care that is person-centred and responds to older people's holistic needs</p>
<p>There are clear, positive correlations between health status, life satisfaction and functional ability</p>	<p>Governments and other stakeholders should take a comprehensive and multi-sectoral approach to healthy ageing that goes beyond a focus on the presence or absence of disease to support functional ability and wellbeing in older age</p>
<b>Barriers to access – health services</b>	
<p>Access to health services declines with age and is lowest among those least able to meet their basic needs, and those with the lowest levels of education</p>	<p>Ministries of Health and other service providers should ensure services and facilities are age friendly and accessible to older people of all ages and levels of ability</p>
<p>Older people in rural areas face greater challenges in accessing health services than those in urban areas</p>	<p>Ministries of Health and other service providers should strengthen primary health care to deliver services closer to where older people live, including in rural areas</p>
<p>Older people's ability to pay for health services is influenced by socio-economic status, with those with the least ability to meet their basic needs and lowest educational levels least able to afford health services</p>	<p>Government ministries, including health and finance, should ensure efforts to achieve universal health coverage are inclusive of older people, considering and responding to the specific income insecurity faced in older age to ensure health services are affordable and older people do not face financial hardship in accessing health services</p>
<p>The oldest age groups, those in rural areas and with lowest levels of education rate the quality of health services available to them most poorly. This suggests inequity in health systems with some groups less able than others to access quality care</p>	<p>Ministries of Health and medical training institutions should invest in developing health workforces and building their capacity on older people's health, and tackling widespread ageism in health systems</p> <p>Ministries of Health should ensure the essential health services included in UHC packages include those most needed to address health challenges common in older age</p> <p>WHO should include age in the range of characteristics that is used to assess equal quality of health services for all</p>

## Access to care and support

<p>Access to care and support for older people is poorest for those in the youngest and oldest age brackets</p>	<p>Governments should develop and strengthen long-term care systems and provide care and support services that target those being left behind; that take into account older people's needs and preferences; and that recognise the heterogeneity in older age</p>
<p>Access to care and support is influenced by socio-economic status, with those least able to meet their basic needs, and with the lowest levels of education least able to access support when they need it</p>	
<p>The support older people are able to access is mostly provided by family members</p>	<p>Governments should recognise, train and support family and community members currently providing care, to ensure adequate quality of care for older people and that those providing care are not negatively affected by their caregiving role</p>
<p>Older men are less likely to engage in self-care than older women, and the extent of self-care decreases with age</p>	<p>Ministries of health and social welfare and other service providers should support older people's ability to self-care, providing older people with gender-sensitive information and education to support them to make changes to their own lives to support healthy ageing</p> <p>With support from governments, civil society should establish community-level mechanisms, including Older People's Associations and healthy ageing clubs, to provide older people with information on healthy ageing, including diet, exercise and where to access health services and support, to enable them to take action to support their own health and wellbeing</p>
<p>The type of actions people take to look after their health varies between contexts</p>	<p>Governments, civil society and other stakeholders should take into account local context and older people's preferences when developing interventions to support self-care</p> <p>Research institutions should undertake further research to better understand older people's ability to self-care and what influences the actions they take</p>

## Impact on health, wellbeing and functional ability

<p>Gender is a significant factor in perception of health status, with older women perceiving their health status to be poorer than older men, despite reporting higher levels of access and engagement with self-care</p>	<p>Ministries of Health and other service providers should provide gender-sensitive services that respond to the specific needs of older women and men, and that address older women's concerns about their health status</p>
<p>Older people's feelings about their health status, functional ability and wellbeing are influenced by age, socio-economic status and location, with the oldest age groups, those in rural locations and those with least ability to meet their basic needs reporting lowest levels of health, life satisfaction and functional ability</p>	<p>Ministries of Health and other service providers should develop targeted health and care services and support that respond to evidence on who is being left behind; that take into account older people's needs and preferences; and that recognise the heterogeneity in older age</p> <p>Governments and donors should ensure data collected on older people's health and care is fully disaggregated by age, sex, disability, socio-economic status and location to provide a strengthened evidence base and enable greater targeting of services and interventions</p> <p>Governments and donors should remove the age limits from population-based surveys such as Demographic and Health Surveys and the WHO STEPwise survey to ensure all older people's age groups are included</p> <p>Ministries of Health should ensure Health Management Information Systems require and facilitate the collection, analysis and reporting of data disaggregated by age, sex and disability</p>
<p>An older person's ability to access both health services and care and support has an impact on their health status, life satisfaction and functional ability</p>	



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