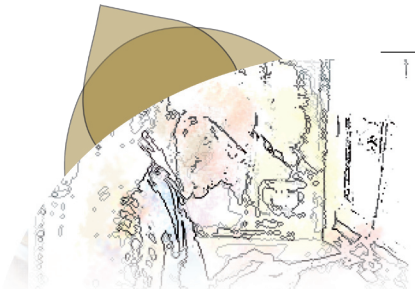

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Models and Systems of Elderly Care

Social Welfare and Health (Mental, Social, Physical) Status of Aged People in Iran

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ABSTRACT

One of the biggest areas of demographic change, commencing in the 20th century, is aging. Average life expectancy at birth has increased by 20 years since 1950, to 66 years and is expected to extend a further 10 years by mid-century. This demographic triumph means that the number of older people will increase from about 600 million in 2000 to almost 2,000 million in 2050. The increase will be greatest in developing countries where the older population is expected to quadruple during the next fifty years (Second World Assembly on Ageing, 2001). According to the latest census taken in Iran, the elderly population aged 60 and older was 6.6% of the whole population (71 million), which will be more than four million. It would be interesting to find out the present situation (Social welfare and health) in such a developing country like Iran.

In this study, after a quick epidemiological aging review in the world, Asia, and Middle East, we will review the Iran census for aged people, in detail. We will discuss the social welfare, and health status of aged people in Iran. In social welfare status, we will focus on issues like social security, welfare, shelter, education, family patterns, and income. In health status, we will focus on different categories: mental health, physical health, and social health. Since old age is associated with more dependency and is concomitant with other related diseases, in order to confront these problems different kinds of health, medical, and economical facilities should be considered.

Because of different consequences (medico-social, psychological, political and economical) of aging in societies, referring to such reports will help the policy makers and care givers develop future planning for aged people. It is necessary for Iran to perform an epidemiological survey to determine aged peoples' needs (social, mental, and physical health) in order to design national framework services.

Introduction

Average life expectancy at birth has increased by 20 years since 1950 to 66 years and is expected to extend a further 10 years by mid-century. This demographic triumph means that the number of older people will increase from about 600 million in 2000 to almost 2,000 million in 2050. Global society is already older than ever before in human history. The increase will be greatest in developing countries where the older population is expected to quadruple during the next fifty years. Such a global demographic transformation has profound consequences for every aspect of individual, community, national and international life. Every facet of humanity will evolve - social, economic, political, cultural, psychological and spiritual (Second World Assembly on Ageing, 2001).

According to the latest census taken in 1996 in Iran, the elderly population aged 60 and older was 6.6% of the whole population and the Census Bureau predicts that the elderly age dominance will be more significant from the year 2030 on. In this regard the elderly population aged over 60 will be 8.5 million in 2020 and five years later in 2025 this will reach up to 10.5 million. This means the population of aged below 5 years will be the same as older than 60. At that time we will have an explosion in the population of the elderly in the country. Since old age is associated with more dependency and is concomitant with other related diseases, in order to confront these problems different kinds of health, medical, and economical facilities should be considered. Aging could not be stopped but the disturbances and disabilities of old age could be prevented or postponed by implementing appropriate care and methods. In order to obtain a detailed and organized program like other countries in the world and many of the East-Mediterranean countries (EMRO) have proposed their seniors' health national program, it was necessary for Iran to perform an epidemiological survey to determine seniors' social and physical health, setting priorities for social and physical health needs, assess the amount of services needed for them and to adopt national policies on caring for this age group.

Aging and life expectancy

By looking at the present and future distribution numbers of aged people (60+) in the world, developed countries, developing countries, Asia, and Iran, we can recognize the increasing numbers in different regions **(Table 1)**.

Health promotion encourages people to control and improve their own health. Goals of increasing the healthy life span, improving the quality of life for all, reducing mortality and morbidity rates, and increasing life expectancy are emphasised in all regions of the world. In **(Table 2)**, the average life expectancy at birth has been shown for the world, developed countries, developing countries, Asia, and Iran. The increasing rates are very important and can be defined as improvement in the human condition.

The remarkable demographic transition underway will result in the old and the young representing an equal share of the world's population by mid-century. Globally, the proportion of persons aged 60 years and older is expected to double between 2000 and 2050 from 10 to 21 per cent, whereas the proportion of children is projected to drop by a third, from 30 to 21 percent. In certain developed countries and countries with economies in transition, the number of older persons already exceeds the number of children, and birth rates have fallen below replacement levels. In some developed countries, the number of older persons will be more than twice that of children by 2050. **Figures (1), (2), and (3)** show the demographic transition of the Iran population from 2000 to 2050 for male and female in different age categories.

As it can be seen the pattern is changing completely in the future. It shows the importance of the aging issue in Iran in the future.

Health Promotion and Well-Being

There has been a different definition for health: Physical, psychological, social and Spiritual well-being is not only absence of disease or disability (Alma-Ata, 2001). Health can be soundness of body and mind, a state of vigor and vitality that permits one to function effectively physically, psychologically and socially. The dimension of health is: Physical, Psychological, Social, Spiritual and Environmental.

Physical health refers to soundness of body. It involves such aspects of physical being as weight, body shape, the sharpness of senses, the ways in which the body functions, and the presence or absence of Disease or infirmity (Nevid, 1998).

Equity in access to health promotion, that includes disease prevention throughout life, is the cornerstone of healthy ageing. A life course perspective involves recognizing that health promotion and disease prevention activities need to focus on maintaining

Table 1

	Present		**Future**				
Year	2000	2005	2010	2015	2020	2025	2030
World	606/426 10%	667/905 10/3%	758/750 11/7%	885/741 12/3%	1/021/974 13/6%	1/179/937 15%	1/348/294 16/6%
Developed countries	231/794 19/4%	243/604 20/2%	266/216 21/8%	291/884 23/7%	318/682 25/8%	343/569 27/7%	361/419 29/1%
Developing countries	342/609 8/1%	387/515 86%	450/159 9/4%	544/249 10/8%	645/097 12/3%	267/977 14/1%	906/451 16/1%
Asia	322/161 8/8%	363/510 9/3%	420/933 10/1%	504/708 11/5%	591/507 12/9%	698/466 14/7%	821/752 16/8%
Iran	4/237 6/4%	4/564 6/5%	5/226 6/9%	6/402 7/9%	7/951 9/2%	9/723 10/7%	11/604 12/3%

Table 2

	Present		**Future**			
Year	2000-2005	2005-2010	2010-2015	2015-2020	2020-2025	2025-2030
World	65/4	66/3	67/2	68/1	69/1	70/2
Developed countries	75/8	76/6	77/3	78	78/7	79/4
Developing countries	66/4	67/3	68/3	69/1	70/1	71/2
Asia	67/2	68/5	69/4	70/2	71/1	72/2
Iran	70/3	71/7	72/8	73/9	74/9	75/9

Fig (1). Iran population demographic transition in year 2000

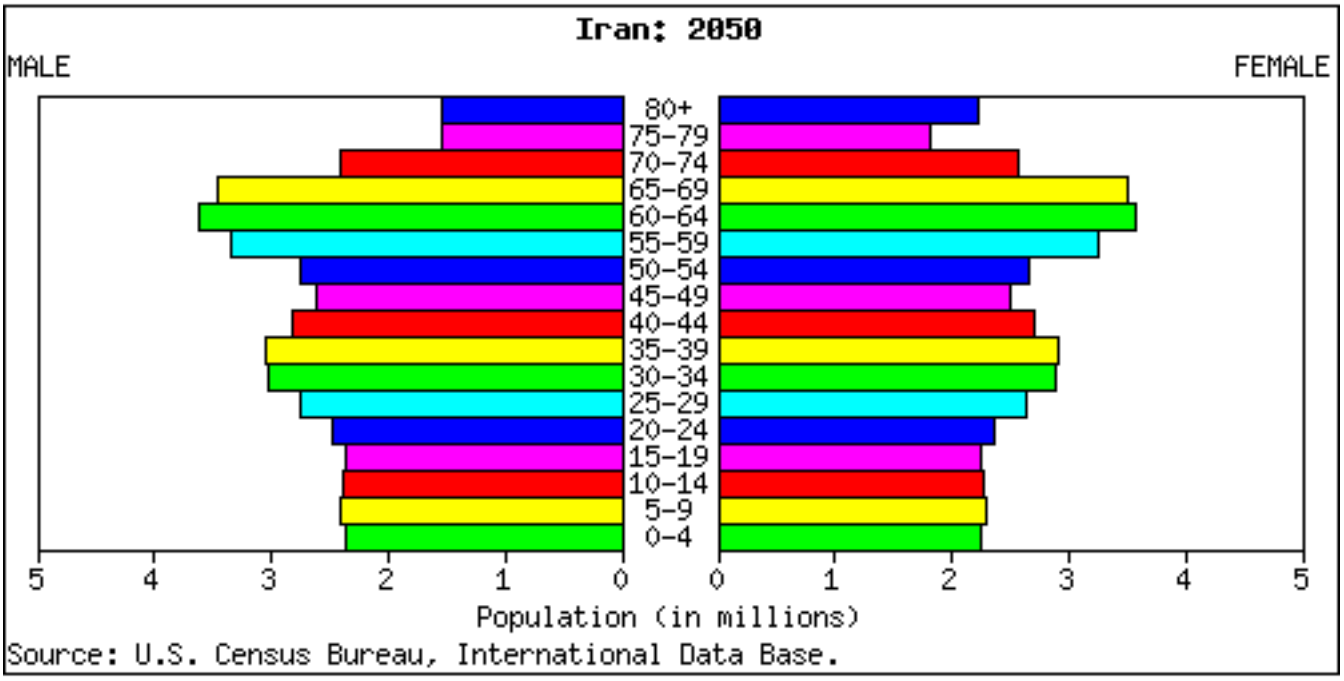


Fig (2). Iran population demographic transition in year 2025

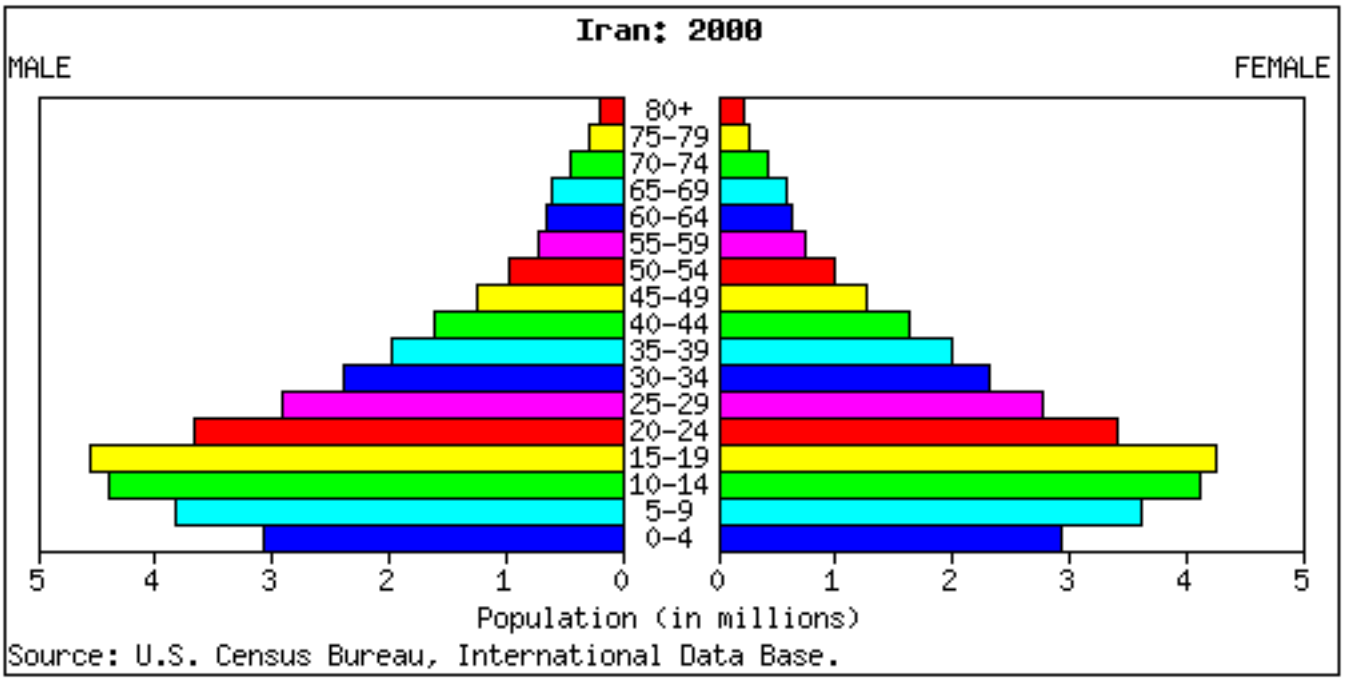
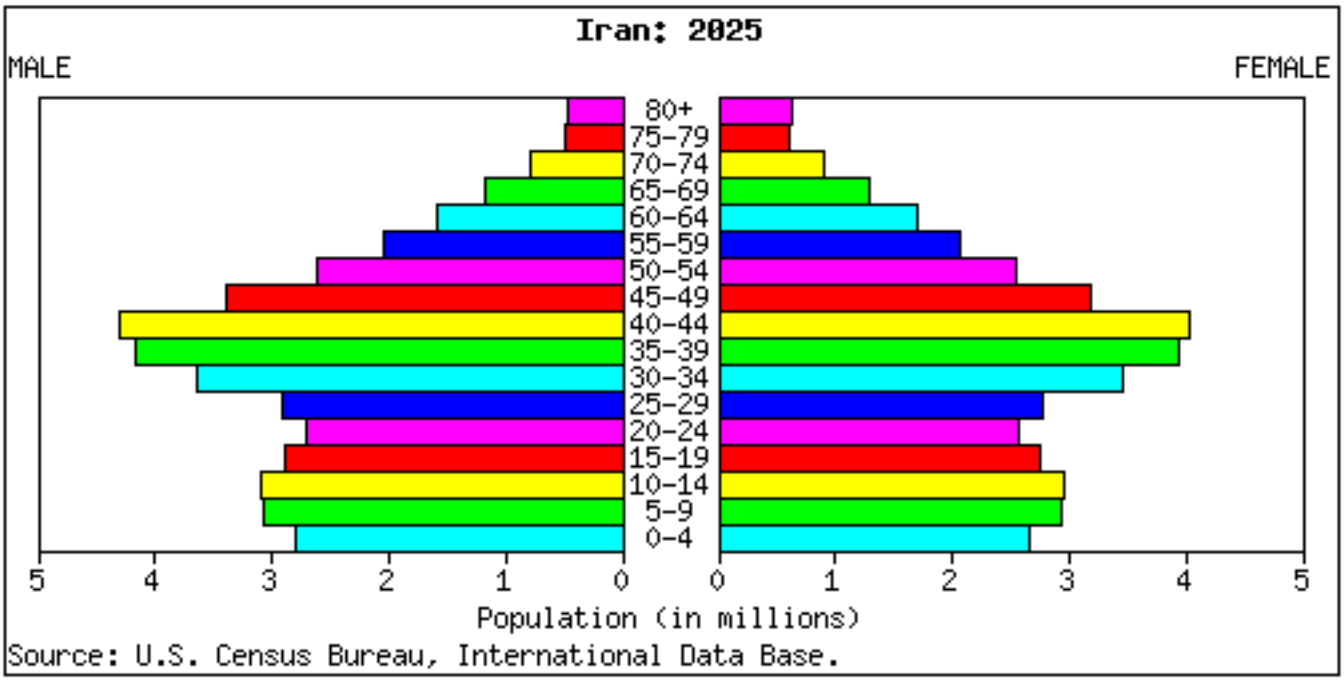


Fig (3). Iran population demographic transition in year 2050



independence, prevention and delay of disease and disability, as well as on improving the quality of life of older people who already have disabilities. Despite improvements in legislation and service delivery, equal opportunities for women through the life course are still not realized in many areas.

A close study to the pattern of disease and disability in aging in countries such as USA, Canada, Korea, China and Iran indicates that Cardiovascular, Arthritis, Cerebrovascular, Accident, Cancer, Hypertension, Ischemia, and body Instability are the most common diseases. In USA the first mortality disease is Cardiovascular, and morbidity is Arthritis (Rubenstein, 1998). In Canada also the first mortality disease is Cardiovascular and morbidity is Arthritis. In Korea the first mortality disease is Cerebrovascular, Accident and morbidity is Arthritis (WHO, 2001). In China the first mortality disease is Cancer and morbidity is Hypertension. In Iran the first mortality disease is Ischemia and morbidity is dizziness **(Table 3)**

Table 3

Prevalence		1	2	3	4	5
USA	Mortality	Cardio vascular	Cancer	Stroke	COPD	Pneumonia
	Morbidity	Arthritis	HTN	Hearing problem	Heart disease	Cataract
Canada	Mortality	Cardio vascular	Cancer	Pulmonary disorder	Digestive disorder	Diabetes
	Morbidity	Arthritis	HTN	Mental disease	Cardio vascular	-
Korea	Mortality	CVA	Heart disease	Pulmonary Cancer	Digestive Cancer	Diabetes
	Morbidity	Arthritis	Low back pain	HTN	CVA	Gastric ulcer
China	Mortality	Cancer	Cardio vascular	Pneumonia	Arthritis	-
	Morbidity	HTN	Diabetes	Heart disease	Cataract	Ophthalmic disorder
Iran	Mortality	Ischemia	CVA	Traffic	Dizziness	Diabetes
	Morbidity	Instability	Ophthalmic disorder	Dismobility	Dizziness	HTN

· HTN: Hypertension
· COPD: chronic obstructive pulmonary disease
· CVA: Cerebrovascular Accident

Older adults are disproportionately high consumers of medical services. Eighty-five percent of the elderly have at least one chronic disease (Manuck, Jennings, Rabin, & Baum, 2000). Chronic disease accounts for more than 70% of deaths in the United States (Brownson, Remington, & Davis, 1998). Almost 50% of people 65 and older have some degree of arthritis, over 30% have heart disease, about 40% have hypertension, 12% have diabetes, approximately 30% have hearing impairments, about 15% have cataracts, and about 10% have had a stroke (Benson & Marano, 1998; Unutzer, Katon, Sullivan, & Miranda, 1999). In 1987, when older adults constituted 13% of the population, 58% of public health care expenditures and 22% of private health care expenditures were for people 65 and older (Darnay, 1994; Palmer, Heaton, & Jeste, 1999).

Mental disorder and Social Status of the Elderly in Iran

There is no mental disorder that is inevitable in old age. Most older people describe their overall well-being as good. Hence there is such a thing as "normal" ageing in terms of mental (as well as physical) health. Nevertheless, as in all age groups, mental disorder is not uncommon in older people and there are some disorders that become more prevalent as age increases. Mental disorder in old age can be divided into two broad categories:
1) Organic disorders,
2) Functional disorders.
The prevalence of mental disorder in elderly people depends on exactly which age group is examined and where they are living. In community surveys of all people aged over 65 years, approximately 5% are found to have severe organic brain disorders (mainly dementia) and a further 5% to have mild symptoms of forgetfulness. 2.5-5% will have depression severe enough to warrant treatment with a further 10% complaining of minor depressive/anxiety symptoms.

In 1998, an Epidemiological Survey research using a cross sectional method on 2000 persons of the elderly over the age 60, among 28 provinces all over Iran, was carried out. As a result the mental disorder and Social Status was as follow:

Overall illiteracy rate was very high among the elderly. 79% of urban females and 95% of rural females were illiterate, on the other hand 50.7% of urban males and 71.5% of rural males were illiterate.

Employment rate was 42-64% among elderly males while just 2.7-9.3% of females were paid employees.

Marriage rate in males was two times more than females, so that 37-42% of females had a husband while 86-89% of males had a wife. The reason for this is that men may marry for a second time following loss of their wives while females remain widowed.

Elderly males have numerous sources for their income such as employment, retiring pensions, possessions, and aids received from their children while females just benefit from aid received from their children.

Household facilities: The elderly of rural areas benefit less from facilities such as water piping, electricity, and toilets in comparison to urban dwellers.

Need Assessment of the elderly:

a. Financial Needs: 63.7% in men and 60.5 in women

b. Hygiene and sanitarian needs: 51% in men and 63% in women

c. Welfare needs: 20% in men and 25% in women

d. Emotional needs such as loneliness, lack of social acceptance, and abandonment were just 9 % in men and 16% in women.

Insurance coverage: 25-30% of the elderly do not benefit from insurance services. There are some insurance service providers such as Medical Services Insurance Company, Organization for Social Security, Armed forces Health Insurance, self-insured and Aid Committee.

Health Status of the Elderly in Iran

According to Survey of the Status of the Elderly of Iran (1998) the health status of elderly is as follow:

Activities of Daily Living (Household and outdoor tasks). The female seniors are less able to take part in outdoor activities such as shopping and transportation.

Sports Activities: Most of the elderly do not take part in sports activities.

· Less than 40% in urban males and less than 20% in rural males

· Less than 21% in urban females and less than 9% in rural females

Average number of physician visits in a year:
14.5 times in urban seniors and 13 times in rural seniors
Urban seniors pay more visits to physicians in relation to rural seniors and women pay more visits in relation to men.

20-25 percent of the elderly experience a trauma in a year that could lead to special therapeutic and medical measures. The most important causes of trauma are:

a. Falls: 11-17%

b. Poisoning (by food or drugs): 4-5%

c. Vehicle accidents: 1-2% in rural areas; 20% in urban areas

Females have more cases of falls in comparison to males, on the contrary males experience more vehicle accidents than females

Hospitalization period:

· Out of 3 urban seniors one of them would be hospitalized for 3 days in a year.

· Cardiovascular diseases are the most important cause of urban seniors' hospitalization

· Eye related diseases are the most important cause of rural seniors' hospitalization

Need for assistive and rehabilitation devices
25% of urban males need eyeglasses or lenses but they do not have one. This reaches to 35% in rural areas. Considering hearing aids this measure reaches to 13% in urban seniors and 16% in rural seniors. There is such a circumstance regarding dental prosthesis or dentorthotics, Wheelchair, crutches, and canes.

Disease and disorders distribution is as follow:

Disorders
1 Movement Disorders
2 Dizziness
3 Balance Disorders
4 High Blood Pressure
5 Suspicious Angina Pectoris
6 Ear Noises or buzzing (Tinnitus)
7 Vision Disorders
8 Hearing Problems
9 Definite Angina Pectoris
10 Urinary Incontinency (urge or stress)
11 Constipation
12 Diabetes
13 Painful urination
14 Urinary dribbling
15 Urinary Incontinency (continuous)
16 Hematuria

Discussion and Conclusion

The changing pattern of diseases observed over recent years from infectious disease to chronic and non-communicable disease is a continuous process of demographic transition and is called epidemiological transition. Epidemiological surveillance has a major role to play in identifying the needs and the rates of mortality and morbidity of aged people in every country. The prevalence of cardiovascular diseases among elderly is high as mortality factor and the most common reason of morbidity in the elderly is Arthritis.

In developed countries such as the USA, more than four out of five people over the age of 65 have at least one chronic health problem. Some like varicose veins are relatively minor, others like heart disease pose more serious health risks. Arthritis tops the list, followed by hypertension, hearing impairment, and heart disease. While longevity is increasing so too is the length of time older people are living with chronic health problems.

In Iran the first survey study related to health and aging was done in 1998. The data collected in that study was subjective so there was not so many reliable data related to morbidity factors and pattern of chronic diseases among elderly in Iran. Five chronic conditions mentioned in that study were from subjective data, for example more than 50% of aged people have a disability on moving and transfer, such as arthritis, osteoporosis and 20% of the old aged had not had any accidents by car or falling in recent year. Some important issues of the study were:

The biggest reason for hospitalization in cities is cardiovascular diseases but in villages is ophthalmic and genitourinary diseases.

Smoking among elderly is 30% for old men and 14% for old women.

The pattern of diseases is not the same in the city and in villages so our planning for covering their needs must be different.

Therefore, we need an objective study about epidemiology of diseases among the elderly in Iran to update the previous studies and clarify the exact reasons of dependency and disability of old people. This kind of research could be a suitable guidance for health authorities and policy makers to design a national framework for an aged health system in Iran.

As the speed of aging in developing countries is more rapid than the developed countries, developing countries will have less time than the developed countries to adapt to the consequences of population aging. Currently older persons represent 6.4% of the world's population (approximately 370 millions); 75% live in developing countries and only 25% live in developed countries. There are different consequences of aging in developed countries and they have a national program for covering old aged medical needs such as: geriatric services, geriatric qualified personnel as physicians, nurses, social worker, physiotherapists, care givers, geriatric and gerontologist networks for orientation of old people and their family, when they need medical or social support.

In Iran, as a developing country, the progression rate of aging and the number of aged people is increasing rapidly and a need for a national framework health system for them is obvious. Iran as an Islamic country with 95% Moslems, has very specific socio-cultural needs, which is mixed with religion. In this collective culture the old people will be supported by their family for all their medical, economic, social and mental needs. Recently because of changing of family size, migration and accommodation problems, there is a trend to transfer elders to nursing homes for better care. Therefore nursing homes grow fast without having enough qualified personnel.

In general, the health policy maker should pay attention to positive socio-cultural factors of the Iranian family. They should encourage the families to keep their old parents in their own family with government support. They should design some cost-effective planning for coverage of aged people needs in the family. Therefore they can stay in their home as long as possible with high quality of life.

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