Elderly in India — Needs and Issues

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The goal of geriatric care considering the high prevalence of chronic illnesses in these patients is focussed on detecting and managing disease rather than curing disease. Crucial to that, in addition is the measurement and promotion of physical function. The elderly tend to be cared for in a variety of settings: home, nursing home, day-care centre, senior citizens out patient department, medical units or intensive care unit depending on the nature of the clinical problem. An elderly patient may have his/her own bias or prejudice about ageing.

Ageing of the population is a significant product of demographic transition. In India the proportion of older persons has risen from 4.9% in 1901 to 5.5% in 1951, 6.5% in 1991, 7.7% in 2001 and will be 12% in 2025. Increased human longevity (currently 64 yrs. in the country) has given rise to greater expectation of health and services necessitating vigorous research in various aspects of health and disease in old age and innovations in providing social and economic services. Further, separate academic departments established in developed societies/countries conduct research and may be in a position to provide comprehensive medicare in intensive setting, rehabilitation and long term care. Dhar has pointed out the relative neglect in provision of facilities for patient care as well as training and development in geriatrics in the Indian context. However, the picture is now changing with the increased awareness at several decision-making levels in relation to multiple health issues related to ageing and care. The awareness, progress and the tempo of medical care and welfare of the elderly is receiving fair attention, though in the interior and rural part of the country, they may continue to face a rather grim situation. The family pattern, the dwelling unit members and the overall mindset and attitudes of individuals have undergone a sea change in the last decade due to urbanization, economic liberalization and consumerism that prevails and thrives.

It is true that both the challenges and opportunities for geriatric medicine are enormous. Innovative approaches and new models of service for health care in the elderly are being practiced in different parts of the country. Adequate and comprehensive data indicating the disease burden and the experience gathered in such set-ups is lacking. However several booklets /directories appear in different regions of the country in several local languages indicating the nature and range of services available. The growth of geriatric medicine as a formal academic discipline in medical schools has been rather slow and needs concerted efforts at the university/council for a for the process to be hastened.

However, concurrent with the advancement of geriatric medicine/services arises an issue—a perplexing dilemma of longevity and compromised quality of life that needs to be considered and resolved to the extent possible.

LONGEVITY AND COMPROMISED QUALITY OF LIFE: A PERPLEXING DILEMMA

Very few people reach old age completely free of disease. An epidemiological transition prevails whereby because of longer survival of man, more and more chronic degenerative diseases will have to be managed. Old age also tends to be characterized by concurrent presence of multiple diseases. Advanced age in fact is a risk factor by itself in the causation of several diseases particularly vascular.

In developing countries infectious diseases and tropical conditions like pneumonias, septicemia and protozoal diseases that tend to get complicated coexist simultaneously with diseases such as hypertension, diabetes mellitus, coronary artery disease, cerebrovascular stroke and neoplasm, situations that were hitherto predominantly associated with the developed nations. Degenerative conditions such as osteoarthritis, cataract and dementia tend to be universal. Nutritional problems do coexist either due to deficiency or poor digestion/absorption.

Of the global population of over 6 billion almost 10% are elderly. Further it is projected that the older population in developing countries will rise much faster than the developed countries. It has to be realised, however that the apparent success of the medical science is invariably accompanied by several social, economic and psychological problems in older persons, in addition to the medical problems referred above. It needs to be understood that many of the problems require life long drug therapy, physical therapy and long-term rehabilitation.

It needs to be appreciated that there is great heterogeneity in the older population. A seventy year
old can run or be just capable of a slow walk or plain wheel chair bound. Geriatrics thus focusses on function rather than the disorder persay. It concentrates on care rather than cure because the diseases tend to be chronic. It stresses on independence rather than freedom from diseases. Maintenance of independent living is the central and core issue in geriatrics.

In spite of all that is stated hitherto, the inescapable fact remains that wherever there is functional decline and debility, the quality of life does get compromised. Economic dependence and social restriction further adds to the gravity of situation. Being cut off from the professional, occupational, social – neighborhood, environ and even from the busy near and dear ones may serve as the last straw on the breaking back. The dilemma of dichotomy of longevity on one hand and an enormously compromised quality of life on the other is indeed perplexing!

A probable solution to the dilemma is the multidimensional approach that comprises not only curative but also non-curative methods of care that are essentially preventive, rehabilitative and ones that pertain to terminal and respite care. Frailty is defined as the loss of person’s ability to withstand minor environmental stresses because of reduced reserves in the physiological function of several organ systems. The frail people are at increased risk of disability and death because they do not have the reserves to respond and maintain adequate homeostasis. In functional terms frailty is defined as dependence on others for activities of daily living (ADL s)- bathing, dressing, feeding, continence, toiling and mobility. Both frailty and disability frequently coexist and the prevalence increases with increasing age. Impaired cognitive function may add to the complexity of the situation.

All in all, the medical/health and social service institutions in the country need to prepare for the demands of care of the frail/disabled senior citizens to minimize the gap between the longevity and associated poorer quality of life.

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