Falling off the health-care radar

The National Health Policy (NHP), 2017 is unable to see the wood for the trees. Life and death questions are dealt with perfunctorily or simply overlooked. For example, it overlooks the rapid rise in the share of the old (60 years or more), and associated morbidities, especially sharply rising non-communicable diseases (NCDs) and disabilities. With rising age, numerous physiological changes occur and the risk of chronic diseases rises. The co-occurrence of chronic diseases and disability elevates the risk of mortality.

Another, more recent report, “Caring for Our Elders: Early Responses, India Ageing Report – 2017 (UNFPA)”, complements the NHP by focussing on the vulnerability of the aged to NCDs, recent policy initiatives and the role of non-governmental organisations in building self-help groups and other community networks. While all this is valuable, it fails to make a distinction between the aged in general and those suffering from chronic conditions. It matters as many suffering from chronic conditions and disabilities may find it harder to participate in such networks. Nor are the important questions of the impact of these networks and their replicability discussed except in a piece-meal manner.

The health system is ill-equipped to deal with surging NCDs; nor is the staff well trained to treat/advise the aged suffering from dementia or frailty, and for early diagnosis and management of conditions such as hypertension. The quality of medical care is abysmal, and hospitalisation costs are exorbitant and impoverishing. Health insurance covers a fraction of medical expenses incurred. However, many of these chronic conditions such as hypertension can be prevented or delayed by engaging in healthy behaviours. Physical activity and healthy diets can mitigate these conditions. Others could be managed effectively if detected early such as diabetes. Some of course can’t be treated but rendered less painful and debilitating through assistive devices such as stroke). Supportive families and community networks often make a significant difference.

Based on the India Human Development Survey (IHDS) 2015, among aged males and females (over 60 years), the proportions of those suffering from NCDs nearly doubled during 2005-12, accounting for about a third of the respective populations in 2012. More females than males suffered from these diseases. The proportions were higher among those over 70, and these doubled in the age groups 60-70 years and over 70.

A vast majority of those with NCDs had access to medical advice and treatment and the proportion remained unchanged during 2005-12. As there is considerable heterogeneity in providers of medical help — from qualified doctors to faith healers and quacks — and a sharp deterioration in the quality of medical services, it is not surprising that the proportions suffering from NCDs have shot up despite high access. Access to government health insurance nearly doubled but remained low as barriers for the aged remain pervasive such as fulfilling eligibility criteria, slow reimbursement and a lack of awareness of procedures. In any case, the proportion of medical expenses covered was measly.

Loneliness and immunity

Loneliness is a perceived isolation that manifests in the distressing feeling that accompanies discrepancies between one’s desired and actual social relationships. The link between loneliness and mortality is mediated by unhealthy behaviours and morbidity. The fact that loneliness predicts health outcomes even if health behaviours are unchanged suggests that loneliness alters physiology at a more fundamental level. Research shows that loneliness increases vascular resistance and diminishes immunity.

We have used two proxies for loneliness: one is single-member households and the other is whether one is married or widowed. Snapping of the spousal bond in old age poses serious health risks. In 2005, old females with NCDs were twice as likely to live in single member households than the corresponding males. In 2012, while the females were two and a half times more likely to be living in single member households, the share of males rose more than moderately. In effect, old females with NCDs became much lonelier.

Whether related to or unrelated to loneliness, a high risk factor for NCDs is daily consumption of alcohol, especially local brews. Daily consumption of alcohol among the aged with NCDs rose more than twice over the period 2005-2012. Banning of liquor sales in a few States hasn't helped because of strong resistance from vested interests including politicians and expansion of illicit sales.

Networking as support

Another measure is the proportion of those married and widowed. More females were married than males while the widowed were much higher among the females in 2005. Both male and female proportions of those married doubled in 2012 but the latter remained larger. While widowed males tripled, widowed females rose just under twice. However, children often play an important role in elderly support with the caveat that filial piety shows signs of diminishing. So if we look at households with 2-4 members, we find that the proportion of aged females with NCDs living in them was much higher than that of males in 2005, and both rose rapidly, especially the latter. So it is arguable that family support more than compensated for the sharp rise in loneliness. An important point is that today, 'women are increasingly filling other roles, which provides them with greater security in older age. But these shifts also limit the capacity of women and families to provide care for older people who need it'.

That social networks are effective in providing support to the aged is far from axiomatic as there are questions of size of a network, whether it is proximal or non-proximal and whether there is social harmony. If social networks are instrumental in bonding together in periods of personal crises, this could compensate for a lack of family support, e.g. widows living alone, and help alleviate morbidity. We find that bonding rose sharply among both aged males and females suffering from NCDs during 2005-12.

The IHDS also provides data on inter-caste and village conflicts, with the proportion of those suffering from NCDs living in villages that experienced inter-caste or other conflicts more than doubling during 2005-2012. Lack of social harmony induces helplessness, disruption of medical supplies and network support.

The World Report on Ageing and Health 2015 (WHO) is emphatic about what is known as ageing in place, that is the ability of older people to live in their own home and community safely, independently, and comfortably, regardless of age, income or level of intrinsic capacity. Ageing in place can be further enhanced by creating age-friendly environments that enable mobility and allow them to engage in basic activities. This reinforces the case that solutions to those with chronic diseases lie within but also outside health systems.

From a policy perspective, health systems have to be configured to deal with not one NCD but multiple NCDs to manage them better. The impact of multi-morbidity on an old person's capacity, health-care utilisation and the costs of care are significantly larger than the summed effects of each. Besides, the reconfigured medical system must be complemented by stronger family ties and social networks. This is not as Utopian as it may seem as examples of such complementarities abound.

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The new U.S. Fed Chairman is unlikely to opt for policies that might upset the President’s plan

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