Healthy ageing and disease prevention: The case in South Africa and The Netherlands

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Medical advances, improved health care and prudent health behaviour undoubtedly contribute to increasing longevity, but gaps remain that undermine individuals' ability to age well. Enormous differences exist across regions and countries in individuals' capacity to plan for a healthy and secure old age. Healthy ageing is largely determined by social and economic opportunities, and health status and access to health care over the life course. Worldwide, older persons carry a greater share of the burden of chronic disease and utilise health care services more intensively than any other age group.

The presentation focuses on opportunities for healthy ageing and disease prevention in two countries: The Netherlands and South Africa. The Netherlands is classified as a developed, or industrialised country, while South Africa is a developing country, albeit with a middle income economy. South Africa has a youthful population (30.5 % of the population is younger than 15 years, compared to17.8 % in The Netherlands), and social and health policy favours the young and marginalises the elderly. The majority of older persons are chronically poor and receive a means-tested non-contributory social pension. The majority is reliant moreover on the public sector for health care, where care may be inadequate. Only 6 per cent of older people in The Netherlands are identified at risk of poverty and every older citizen benefits from a three pillar pension system. Previously, health issues for Dutch older people included inadequate management of complex health conditions, but recent innovative programmes are helping to close this gap.

The presentation focuses less on a comparison of situations pertaining to healthy ageing and disease prevention in the two countries, than on an identification of commonalities in the situations, and action needed to improve health care and prevent disease and disability in later life.

Population profiles

South Africa's total population of 49.2 million is three times as large as that of The Netherlands' 16.7 million. More than a fifth of The Netherlands' total population, 21.4 per cent (3.5 million persons), is aged >60 years, compared to only 7.1 per cent (but 3.9 million persons) in South Africa. Increasing longevity in both countries will see the Netherlands' older population increase to 31.3 per cent (of the total population) by 2050, and a doubling of South Africa’s older population (to 14.2 %). Life expectancy at birth in The Netherlands will increase from 80 years in 2009 to 84.2 years by mid century, and in South Africa, from a low 51.6 years – due to AIDS related mortality, to 62.3 years. The Dutch population aged >80 years will increase from 3.9 to 10.5 per cent (of the total

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population), and in South Africa it will quadruple from 0.6 to 2.2 per cent (UNPD, 2009). Growth in the oldest age group will have implications for the management of increased chronic morbidity and disability.

Epidemiological profiles

The disease profiles of older persons in the countries, specifically morbidity due to non-communicable, or chronic disease (NCD) and related disability and mortality, are as follows: In The Netherlands, circulatory disease has a lower mortality rate in persons aged >65 years than the European average, but cancer mortality, mainly due to lung cancer (and the "tobacco epidemic"), is relatively high. Similarly, mortality rates for respiratory disease (COPD) are high, and the prevalence of diabetes is increasing. Injuries and poisoning account for 130/100 000 deaths in men and 100/100 000 deaths in women, with falls responsible for 90 per cent of fatal household accidents in persons aged >55 years. Chronic joint pain and osteoarthritis are the most common causes of limited mobility and dependence in the older population, with osteoporosis a major health threat to Dutch older women.

Major depression is relatively rare, but depressive symptoms are very common (estimated at between 9 and 15 per cent of the older population). Dementia is the most common age related mental disorder and a rapid rise in the prevalence of Alzheimer's disease is expected. Overall, two thirds of Dutch older persons report at least two chronic conditions; at age >85 years, 85 per cent do so – mainly arthritis, diabetes and heart disease. No clear data are available for disabilities, but disability free life expectancy at age >65 (9.5 years for both men and women) and healthy life expectancy (10.4 years for men, 10.9 years for women) are low.

In South Africa, NCD accounts for 84 per cent of all deaths in persons aged >60 years, with ischaemic heart disease and stroke leading single causes of death in men, the order reversed in women, and together accounting for about one third of deaths. Over 60 per cent of women aged >65 are hypertensive, and deaths from hypertensive heart disease are twice as high in older women than in older men. COPD accounts for almost double the number of deaths among men than women. Malignant neoplasms are responsible for 16 per cent of deaths in older men and 10 per cent in older women, with lung cancer predominating in men and breast cancer in women. Injuries, due to traffic accidents, and homicide/violence, and suicide, account for 3 per cent of older person deaths. Overall, hypertension is the most commonly reported chronic condition in both men and women, followed by arthritis.

South Africa lacks representative data to estimate the prevalence of dementia in the older population. High rates of depressive symptoms in this population have been established in community surveys (a rate of 66 per cent (44 % for women, 25 % for men) in Khayelitsha, a newly settled township of Cape Town (Gillis, 1992)), and the rates attributed to the effects of urbanisation, compounded by poverty, a poor environment, and stress relating to coping and

the burden of care in older women. Sixteen per cent of older South Africans report having a disability – most commonly vision and physical.

Risk factors for NCD

Risk factors for chronic disease in later life stem partly from lifestyle behaviour and inadequate health care over the life course. In The Netherlands, 12 per cent of older men and women were classified in 2007 as moderately obese, and 2 and 4 per cent, respectively, as severely obese; the obesity has been linked to diabetes, hypertension and arthritis. In 2004, 30 per cent of the population aged >50 years used tobacco, and 20 per cent of men and 10 per cent of women in that age group reported high alcohol consumption. Screening for diabetes, a risk factor for cardiovascular disease and disability in elderly persons, is sub-optimal, and high cardiovascular risk often goes undetected and untreated. A lack of evidence is viewed as a deterrent to the introduction of preventive health care programmes.

In South Africa, particular risk factors for chronic disease, especially cardiovascular disease, are hypertension, high cholesterol and obesity, attributed partly to a rapid urbanisation trend, and in-migrants' adoption of a largely sedentary lifestyle, a diet rich in fats, salt and sugar, and increased tobacco and alcohol consumption. Hypertension is typically poorly managed and patient awareness low. Twenty-nine per cent of older men are overweight and 14 per cent are obese, with corresponding figures for older women 27 and 33 per cent, respectively. Thirty five cent of older men and 7 per cent of older women currently use tobacco daily. Slightly less than half of older men and a fifth of older women currently consume alcohol.

Health service provision and accessibility

The Dutch health care system is highly effective in most areas of acute, chronic and preventive care, but was possibly less efficient until recently in the management of multiple morbidity in older persons, with geriatrics neither fully integrated in the system. In South Africa, only two universities have a geriatrics department and geriatric care is given short shrift in public health. Transformation of the public health system in 1994 to focus on primary care means that 92 per cent of all cases are now managed at the primary level and only 2 per cent are referred for tertiary level care (6 % to secondary level). The marginalisation of geriatric services has impacted the delivery of preventive, curative and rehabilitative care to the older population severely.

In both countries, older citizens encounter access barriers to health care, but far more so in South Africa. Only 13 per cent of older South Africans have health insurance – and are able to access private care, whereas all citizens in The Netherlands have health insurance, with low income residents covered through a public risk equalisation care allowance. Access barriers contribute variably to poor management of health conditions, client dissatisfaction, and lost opportunities for the detection, management and prevention of chronic disease and co-morbidities in the countries. User dissatisfaction with public health services in South Africa is extremely high.

Response programmes

Innovative programmes in response to older persons' health care needs and to prevent disease in the countries are reviewed briefly. In The Netherlands, a four-year National Programme on Elder Care, co-ordinated by ZonMw, The Netherlands Organisation for Health Research and Innovation and financed by the Ministry of Health, operates through tertiary level geriatrics departments and a network of medical organisations to improve care for older persons with complex health problems. The Leyden Academy on Vitality and Ageing (LAVA), a privately funded training facility develops young medical professionals interested in the optimisation of health care for older persons, and will shortly offer executive training on ageing and health to non-clinical managers of long term care facilities and hospitals, as well as professionals at local authorities, insurance houses and finance departments. The Top Institute on Healthy Ageing (Ti-Go), established recently by academic centres, other research institutes, health care providers, health insurance houses and electronics industries, is a major multidisciplinary effort in partnership with stakeholders aimed at providing expertise and infrastructure to researchers, clinicians, policy makers and key organisations working to promote healthy ageing.

By contrast, programmes in South Africa are paltry. The older population remains fairly "health illiterate," and health professionals typically lack knowledge and skills to treat and educate older clients. A focus on acute and symptomatic care translates into few opportunities available to screen for pre-symptomatic illness. Two fledgling programmes nevertheless are: 1) A programme to promote healthy lifestyles and control NCD, run by the health ministry in partnership with NGOs, under which health care workers at community health centres are trained to "educate" clients in the community. After management and "education" at a centre, and goals have been set, a client is referred to a community based support group, to continue education in self-management of the condition, where it is also monitored. 2) A cataract surgery programme, in co-operation with national, provincial and district committees for the Vision 2020: Right to Sight: Prevention of Blindness campaign, screens older persons for eye problems at pension pay points and old age homes, and refers those with a problem for visual acuity assessment and possible surgery.

Conclusions

The realisation of healthy ageing and disease prevention as universal goals for societies and governments lags far behind in South Africa compared to The Netherlands. Following on concerted lobbying and awareness efforts of ILC The Netherlands, among other organisations, the country's health system is exemplary in providing adequate care services for older persons with chronic disease and disability. In South Africa, health care for the majority of older people is far from adequate and disease prevention sorely under developed. A major challenge for both countries is how to manage health care provision optimally, in order to improve the health status of growing numbers of older persons, and to prevent

chronic disease and disability effectively and efficiently.

The Netherlands has adopted an integrated approach to the multiple health problems of older people, helping them gain healthy life years by preventing or delaying the onset of disease and disability, promoting self-management and functional autonomy, and fostering support for older informal carers. South Africa continues to face numerous broad development challenges, and ILC South Africa works concertedly to mainstream improved and expanded health care services for older citizens in political agenda. Bilateral exchanges of knowledge, systems, clinicians, professionals and students between the countries are mooted, towards achieving health equity and fostering health literacy in the older population.

References

Gillis, L.S. 1992. Depression in newly urbanized elderly Africans. *Southern African Journal of Gerontology*, 1(1): 20–24.

United Nations Population Division. Department of Economic and Social Affairs. 2009. *World population prospects: The 2008 revision. Highlights*. New York: UNPD.