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DEVELOPMENT OF HUMAN RESOURCES AND IMPLICATIONS OF AGING SOCIETIES

COUNTRY REPORT
MALAYSIA

DEMOGRAPHIC AND HEALTH STATUS OF MALAYSIAN ELDERLY

All countries in the world has an ageing population although the rate of ageing is not the same. In Malaysia, the 40 year span since independence has increased life expectancy considerably. In 1957, the life expectancy at birth of a Malaysia male is 55.8 years and females, 58.2 years. In 2002, the life expectancy at birth of a Malaysia male is 70.3 years and females, 75.2 years. A major factor in population ageing is declining fertility and mortality.

The Malaysian population is relatively young compared with that of developed countries, but changes in the age structure have brought about the ageing of the population. Malaysia uses the cut-off age of 60 years to define `elderly' or `older persons'. Currently the total population is 24.5 million, and 1.5 million or 6.3% are above the age of 60 years (2002). The number above 65 years is estimated to be 1 million (4.1%). Malaysia is expected to reach the aging phenomenon by the year 2005 where the elderly population will reach 7.2%. By the year 2025, it is estimated the elderly population will grow to 4.2 million or 11.0%.

A study by the Ministry of Health (1995) among the rural elderly showed that 77.1% of the elderly were able to move independently, and 1.3% were bedridden. Another study (National Population and Family Development Board, 1991) showed that 16.5% considered themselves as in 'good' health and 69.7% considered themselves as in 'fair' health. The study also showed that 81.4% suffered from at least one chronic medical illness and 12.7% had 3 or more.

RURAL URBAN DIFFERENTIAL

The drive towards industrialization has attracted the young rural people to move to towns and cities, where industries are located, leaving behind the elderly in the village who very often have to fend for themselves. Fortunately for Malaysia, the health care system in rural areas is well established with good access, and most rural families still hold on to the traditional values where kinship is important and older persons are generally looked after by other family members. A challenge is therefore to ensure that this tradition is maintained in the face of rapid change and globalization.

FEMINIIZATION OF AGEING

Females tend to outlive males and there are more widows than widowers in most countries, including Malaysia. Population data in 2002 shows that 738,500 elderly males as compared to 805,700 elderly females. There are more elderly men, 76.1%, living with their spouses compared to 29.7% elderly women. This is due to variance in morbidity patterns between the sexes. This larger and increasing number of ageing women has its own social and health implications on policy and programmes.

THE NATIONAL RESPONSE TO THE AGING PROBLEM

Recognizing the aging phenomena and its implications on health and socio-economy in the country, a programme for the elderly was established in 1995. A National Policy for the Elderly was developed under the purview of the Ministry of Unity and Social Development (Now, called the Ministry of Women, Family Development and Community). A National Plan of Action for Older Persons and an accompanying budget was approved by the Cabinet in 1998. Various committees were formed to coordinate activities pertaining to health; social and recreation; housing; religion, education, training and research.

HEALTH SERVICES FOR THE ELDERLY

The health care for the elderly was introduced by the Ministry of Health Malaysia in 1996. A National Plan of Action for Elderly Health produced in 1997 addressed health care at the primary, secondary and tertiary levels. The annual budget for elderly care at the primary health care level is about RM 1.6 million per year, accounting for preventive and promotive activities. There are no special budget for geriatrics services as it is integrated with the other hospital services. The health care covers the whole spectrum of services namely :

a. Health promotion and prevention

   Various health education materials have been produced for the general public on specific topics namely understanding the aging process, nutrition, oral health care, medical examination, osteoporosis, insomnia, arthritis, mental health and exercise. A manual for care givers are available. A healthy lifestyle campaign in 2000 themed ‘promotion of healthy family’ gave focus on the health of elderly as an important member of the family entity.

b. Treatment of illnesses

   The wellness approach in the provision of care for all ages, as adopted by the Ministry of Health, will contribute to healthy ageing and ensure quality of life of the elderly group. At the primary health care level, services provided are aimed at ‘keeping the well elderly healthy’. These include health promotion and education, health screening and assessment, medical examination and treatment, counseling and recreational, social and welfare activities. In 2002, there are 513 or 60% of government health clinics in the country carried out these services for the elderly. Some activities are integrated with other services namely, care for the disabled,

reproductive health and specific services for diabetes and cardiovascular diseases. Geriatric services are provided in 3 government hospitals only – Hospital Kuala Lumpur, Hospital Seremban and Hospital Banting – and 1 university hospital i.e. University Malaya Medical Centre. Provisions are made to facilitate elderly friendly services e.g. elderly friendly structures, priority in waiting lines, free treatment for pensioners and affordable hospital fees for the poor elderly. Incremental development of geriatric services with priority given to states with a high proportion of elderly people is planned. Geriatric hospital services are organized by different levels of care based on models for centre of excellence, state hospital and district hospital.

c. Rehabilitative and extended care

Rehabilitative services are provided at the hospital level, but more often than not, this is decentralized to where the patients live, such as the health clinics, ambulatory care centres and even the community. Home care nursing is another modality that is implemented on an incremental basis by the Ministry of Health, although NGO's and private sector are encouraged to complement such services.

d. Education and training

By 2002, a cumulative total of 10,159 health staff (family medicine specialists, medical officers, dental officers, nurses, medical assistants, physiotherapists and occupational therapists) have been trained on primary health care services for the elderly. At the same time, a total of 9,387 care givers comprising of home carers and volunteers have been trained by the Ministry of Health. These are people who provide services to maintain the frail elderly in their own

homes or community. Even though doctors are encouraged to specialize in elderly care, training of geriatricians and gerontologist have been slow. Currently, there are 3 gerontologists, 3 geriatricians and 2 psycho-geriatricians in the Ministry of Health, 5 geriatricians in the universities and 1 in the private sector. Since 1991, there are 84 paramedics trained in geriatric nursing.

INTERAGENCY COLLOBORATION

This is an important strategy in meeting the objectives of the National Policy for Elderly and non-governmental organizations and professional bodies work closely with the government in policy formulation, planning and implementation of activities. The National Council for Senior Citizens of Malaysia (NACSCOM), an umbrella body, representing various NGOs encourage and support senior citizens to remain in the mainstream of society through activities such as establishing day care centres and homes, initiate income generating projects and promote continuous education. Community based programmes are run by local organizations e.g. *Panel Penasihat* (the board of advisors of health clinic) and *Kelab Warga Emas*, clinic-centred clubs established throughout the country.

CHALLENGES FACED

While the services at the primary care level have shown tremendous progress, there are inadequacies in the current geriatric services in the hospital. These are:

1. *Lack of appropriate facilities*

   As rule in the hospitals, patients are admitted into the general medical wards first before being managed accordingly by the geriatrician, and subsequently transferred to rehabilitation wards. The current setup in the general medical wards does not have the requirements for geriatric

services. The physical environment does not enable the elderly patient to be functionally independent

2. *Training of undergraduates / postgraduates*

Geriatric care is not formally included in the training of medical undergraduate except for one university in Malaysia. The field of geriatrics is a sub specialization that is not popular among the postgraduates, even though there is a programme established in one of the university hospitals. The number of geriatricians and gerontologists have not increased significantly to be able to meet the needs of the future.

3. *Posting of trained staff*

Trained staff is posted to fill gaps in the general medical wards and this leads to a person working without other members of a team. There is inability to develop comprehensive geriatric services as a result of the mismatching of personnel, and more often than not, the general medical workload becomes the main focus rather than the development of geriatrics

4. *Lack of training of specific skills*

A few hospitals have begun geriatrics services as a specialty but needless to say, management of older ill persons necessitates a multi-disciplinary approach. There are no centre providing training for special teams to manage specific and common problems in geriatric care e.g. falls, incontinence and dementia.

RECOMMENDATIONS

a. *Review of Plan of Action*

There is a need to review the Plan of Action since its inception in 1997 because of many overtaking events and competing priorities.

b. International Cooperation and Collaboration

The primary area for international collaboration would be in human resource development for geriatrics. Several collaborative measures, including the following, can be undertaken;

(a) Identify and develop centres of excellence for geriatrics in the region;

(b) Providing financial support for specialist and sub-specialist training; and

(c) International exchange of medical and non-medical expertise in the management of ageing societies.

c. *Research and Development*

Strengthening of research on older persons for purpose of policy development in areas related to appropriate retirement age, re-training of retirees, financial implications of aging and profile of the older persons in Malaysia including the neglected older persons.

CONCLUSION

Malaysia is on its way to ensure the elderly people live as normal a life as possible. To this end, the objectives of the health system to improve and maintain the health and functional outcome of the elderly, to create conditions that promote quality of life and to enable them to work and live independently, may appear to be far reaching but with concerted efforts by all, it will be a vision realized.