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OF  
WHO INTER-REGIONAL WORKING GROUP ON  
HEALTH CARE OF THE ELDERLY  
IN DEVELOPING COUNTRIES OF  
ASIA AND THE PACIFIC

*Health services for  
aged - Long  
Asia  
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HEALTH CARE OF THE ELDERLY IN DEVELOPING COUNTRIES  
OF ASIA AND THE PACIFIC

Report on a WHO Inter-Regional Working Group

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Note

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## SUMMARY

A United Nations World Assembly on Aging will take place in 1982. Preparatory activities planned by the United Nations Secretariat include technical expert and intergovernmental meetings at the regional level, which will be organized jointly with the UN Regional Economic Commissions. Two such meetings are scheduled in the Economic and Social Commission region of Asia and the Pacific (ESCAP), namely a technical expert meeting on aging held in Bangkok from 26 to 30 January 1981 and an intergovernmental meeting to be held in Manila from 19 to 23 October 1981.

The present Working Group met in order to report to the WHO Regional Directors for the Eastern Mediterranean, South-East Asia and the Western Pacific on the care and wellbeing of the elderly in the countries in their Regions, particularly in relation to the goal of health for all by the year 2000. Since information on the elderly is sparse, the present report is intended to provide a core around which fuller regional documentation can be developed for the above-mentioned ESCAP meetings and other regional preparatory activities related to the 1982 World Assembly on Aging.

The Inter-Regional Working Group comprised 12 participants drawn from 11 countries and areas in the three WHO Regions - Eastern Mediterranean, South-East Asia and Western Pacific - which span the ESCAP region. Although representation was not fully comprehensive of all ESCAP countries, major population groups were covered in four ESCAP subregions, namely Middle South Asia (India and Pakistan), East Asia (China, Hong Kong, Japan, Republic of Korea), Eastern South Asia (Malaysia, Philippines, Singapore and Thailand) and Oceania (Australia).

The Working Group was held simultaneously with the inaugural congress of the regional grouping for Asia and Oceania of the International Association of Gerontology.

The report describes changes predicted by the year 2000 in population and mortality, together with trends envisaged in morbidity and in the provision of care. The impact of development on care of the aged is also analysed, particularly the effect of changes in family structure and of urbanization.

In contrast to the expected 7 million increase of aged persons in the United States by the year 2000, India will experience, in the same period, an increase in the number of persons over 65 years by 17 million and China by 32 million. Taking only the very old, that is those aged 80 or over, there would be 1 million more in Japan by the year 2000, but some 2.2 million more in India and some 5.7 million more in China. These increases have considerable implications for resource provision which must be set against a background of looming resource debts which, in certain countries of the region, are of gigantic proportions. However, the projected change towards diminished dependency augurs well for developing economies, although the structure of dependency will change somewhat, with an increase of elderly dependants who are likely to require more resources than younger dependants.

The continuing trend in mortality is downward. Expectation of life at birth is increasing in all countries represented in the Working Group and actual mortality decline may be greater than that predicted from United Nations life tables. Available data from China, India, Pakistan, Philippines and Singapore indicate that cardiovascular and other degenerative diseases are prominent causes of death in the elderly, although diseases which have their roots in socioeconomic causes such as respiratory disorders (including tuberculosis), infective and parasitic diseases are also reported. The morbidity pattern appears, however, to be moving away from a high level of prevalence of communicable diseases. With development will come the diseases of development, namely degenerative diseases, and also probably mental disorders because of the expected increase in the number of very old people in the last two decades of the century.

Concerning trends in service provision, the primary responsibility for the health of the elderly will remain with the elderly themselves and with the family. The present pattern of health care provision is expected to change radically by the year 2000, since several countries have established plans for the provision of primary health care. For instance, in Thailand, the policy of Health for All by the Year 2000 specifically includes the aged.

Care of the elderly is seen essentially as a nursing function, although the names attributed to the person performing such functions vary from one country to another. A WHO position paper giving a paradigm of the nursing role might help to improve the quality of care that old people receive. This would highlight the interrelationship of nursing personnel to the physician and other members of the health team. Such a paper might also help to get nursing services into the

community, since the concept of nursing as a hospital-based service tends to prevail in developing countries. Important exceptions are Malaysia and China where, respectively, public health nurses and barefoot doctors work in rural areas where the majority of the elderly live. Community nursing practice is seldom carried out by fully trained nurses but rather by people selected from the village or the community who are given short courses of training. In this case, the scarce professional nurse has an important role to play as teacher.

Traditional medical care is often more desirable to the elderly than western medical care. Indeed, western health facilities are grossly under-utilized by the elderly, although this might be overcome if more consideration were given to old people who travel long distances to wait in long queues for care.

The impact of development is shaking the roots of social institutions in the developing world, especially the family structure. In the next decade, policies of the one-child family in China and of the two-child family in the Republic of Korea are likely to be realized, and the full impact of this on family life cannot be foreseen. The potential contribution of the elderly to society remains unrealized. Family life has been completely changed in certain local situations by frequent crises that have resulted in large-scale migration and population movements. The migration of young people to the cities is a feature of Asian countries. In this situation, the elderly are left to look after the homes and farms. In India, by the year 2000, the urban population is expected to increase by 175%. With urbanization, housing conditions change and there is a particular problem of space for the elderly. Here the experience of Japan has key importance for the developing world. The sense of respect and responsibility towards the elderly, as well as the tradition of family support and care of aged parents, are very well maintained despite the rapid industrialization and urbanization. Several governments have policies directed at maintaining this family cohesion and traditional respect for the elderly.

Finally, a standing regional panel or "brains trust" is proposed, to keep the situation of the elderly under constant review. The functions of the panel would include evaluating various intervention programmes, promoting research and ensuring international cooperation in programmes for the aged.

### 1. Collaboration with the International Association of Gerontology

The present activity was developed in collaboration with the International Association of Gerontology (IAG). The IAG is an interdisciplinary, nongovernmental organization in official relationship with the United Nations. It holds biennial world congresses, the next being the XIIth Congress which is to be held in Hamburg from 12 to 17 July 1981. The Association is in the process of extending its regional groupings,<sup>a</sup> and when the World Health Organization (WHO) was informed that the Regional Association for Asia and Oceania was to be launched by an inaugural congress to be held in Melbourne from 30 November to 5 December 1980, the opportunity was taken to convene a WHO Inter-Regional Working Group during the IAG regional congress.

### 2. Contribution to preparations for the 1982 United Nations World Assembly on Aging

The meeting of the Inter-Regional Working Group on Health Care of the Elderly in Developing Countries of Asia and the Pacific was timely, since it preceded the United Nations Regional Technical Meeting on Aging for Asia and the Pacific held in Bangkok from 26 to 30 January 1981 and the Regional Intergovernmental Preparatory Meeting for the World Assembly on Aging to be held in Manila from 19 to 23 October 1981, both meetings being organized jointly by the UN Economic and Social Commission for Asia and the Pacific (ESCAP) and the UN Centre for Social Development and Humanitarian Affairs, Vienna, as preparatory activities for the United Nations World Assembly on Aging which is to take place in Vienna from 26 July to 6 August 1982.

The IAG Regional Congress was itself part of the Association's preparations for the 1982 World Assembly on Aging, since IAG Regional President, Professor Gary Andrews, will transmit a report on regional concerns to the International Congress in Hamburg in July 1981, and the International President, Dr Motatska Murakami, had been asked to report to the UN Regional Meeting in Bangkok in January 1981.

### 3. Participants

Participation in the Working Group was limited to 12 invited members (Annex III), drawn from the 14 countries represented at the Regional Congress. Three WHO regions were represented, namely Eastern Mediterranean (Pakistan), South-East Asia (India and Thailand) and Western Pacific (Australia, China, Hong Kong, Japan, Malaysia, Philippines, Republic of Korea, Singapore). Dr Banloo Siripanich (Thailand) served as Chairman of the Group and Dr M.S. Gore (India) and Dr Ng Yau-Yung (Hong Kong) acted as Rapporteurs. The WHO Regional Office for the Western Pacific was represented by the Nursing Adviser who acts as Focal Person for Care of the Aged in that Office, and the Secretary of the Group was the Manager of the WHO Global Programme for Care of the Aged.

An unusual feature was that the Group included eight participants whose attendance at the Congress was supported by non-WHO funds. These participants nevertheless prepared for the WHO Working Group and participated in its sessions, in the same way as the four WHO-supported participants. The Working Group sessions were closed sessions which were not open to other Congress participants.

### 4. Outcome

The outcome of the Working Group meeting is the present report to the WHO Regional Directors for Eastern Mediterranean, South-East Asia and Western Pacific concerning the care and wellbeing of the elderly, particularly in relation to the Organization's goal of Health for All by the Year 2000. Although not fully comprehensive of all developing countries in the Regions, the Working Group provided a perspective on major population groups of the ESCAP subregions of Middle South Asia (India and Pakistan), East Asia (China, Hong Kong, Republic of Korea) and Eastern South Asia (Malaysia, Philippines, Singapore and Thailand). Since information on the status of the elderly in these regions is sparse, the present report will provide a core around which fuller documentation can be developed for any WHO contribution to the 1981 ESCAP regional intergovernmental meeting for the United Nations World Assembly on Aging referred to in section 2 above.

### 5. Health for the elderly by the year 2000

The tables constituting Annex I and the Group's working documents listed in Annex II provide information on predicted changes in population and mortality together with trends envisaged in morbidity and in the provision of care for the elderly. The documents also analyse the impact of development on care of the aged, particularly the effect of urbanization and of changes in family structure.

<sup>a</sup> Regional Associations exist for Latin America and North America.

### 5.1 Definition of the "aged"

The problem of defining the age at which people become "aged" was resolved by accepting a multi-tier concept, corresponding to the use to which the definition is put. Considering first a definition for health care purposes, there is a need for a somewhat high level, certainly beyond 65 years in the developed countries, and the level of this is dynamic, moving up with the rise in expectation of life at birth. This is to say that in defining the aged for the purpose of meeting special health care needs, there is a continuing upward trend. Second, there is a need to define the aged for economic purposes: this is to say in relation to the age of withdrawal from the labour force, and the trend in this direction is downwards. Third, for the purpose of demographic comparison, the UN proposal<sup>a</sup> to accept the age of 60 years seems most appropriate, given the present situation in developing countries of Asia and the Pacific where the expectation of life at birth is relatively low.

### 5.2 Dependency ratios

Projected changes in dependency ratios between 1975 and the year 2000, in all countries except Japan, are towards diminished dependency, which augurs well for the economies of the developing countries. However, the structure of dependency will change somewhat, with an increase in elderly dependants, who are likely to require more resources than younger dependants. Nevertheless, resource provision for dependants aged 60 years and over cannot be at the expense of provision for those under 15 years, in the situation in the developing countries.

### 5.3 Projected number and proportion of the aged

The improvement in health levels achieved during the last two decades will give rise to the problem of providing resource support for the increasing number of elderly over the remaining two decades of the century. The demographic data in the tabulations (Annex J) are presented as absolute numbers, which is not the normal procedure but is one which calls attention to the increasing need for resources, which is of strategic importance to policy makers. Also the possibility exists that there may be a more rapid actual decline in aged mortality than projected, which would give an unexpected increase in the number of elderly in the future. Present mortality decline certainly appears to be faster than that predicted from the UN life-table population models. However, it is mortality in early age that appears to be declining faster than predicted.

Although the number of elderly have to be estimated for the purpose of service provision, it is no less important to look at the proportion of aged, which is mainly determined by fertility transition: for example, in Japan, the proportion of the population aged 65 years and over will increase from 8.8% to 14.0% between 1980 and the year 2000.

### 5.4 Family consequences of family planning policies

In China the policy is for the one-child family and in the Republic of Korea for the two-child family. These policies seem likely to be achieved in the next decade, and the policy makers in those countries are considering the implications. Almost certainly such policies will increase the role of the extended family in providing mutually supportive care which was previously provided within the large single family.

### 5.5 Increasing needs, diminishing resources

There is certainly reason for concern about the increase in absolute numbers of elderly between the years 1980 and 2000. It should be noted that, in contrast to the expected 7 million increase of the aged in the United States of America and the expected 10 million increase of aged citizens in the USSR (not tabulated), India will experience an increase in the number aged 65 years and over by 17 million, and China by 32 million by the year 2000. Taking only the very old, that is those aged 80 or over, there would be over one million more in Japan by the year 2000, but some 2.2 million more in India and some 5.7 million more in China (not tabulated). These increases have considerable implications for resource provision. Needs of the elderly must be set against the background of the looming resource debts which, in certain countries, are of terrible proportions. Thus any solution to the provision of service resources for the elderly must take account of an expected widening of the resource gap and any proposals have to be implementable in this situation.

<sup>a</sup> For the purposes of the World Assembly on Aging, the aging are defined as those who are 60 years of age and over. (Problems of the elderly and the aged: Report of the Secretary-General. United Nations, 1980, document A/35/130.)

### 5.6 Trends in health and health care

The continuing trend in mortality is downwards: expectation of life is increasing in all the countries represented in the Working Group. This, however, shows wide heterogeneity, the expectation of life at birth ranging from 50 to 55 years in India and Pakistan; 60-65 years in China, the Philippines and Thailand; 65-70 years in Singapore; 70-75 years in Hong Kong; and over 75 years in Japan. The morbidity pattern is also in transition, away from the high prevalence of infectious disease in the past and more towards the pattern of chronic degenerative disease. With development will come the diseases of development, namely degenerative disease, and mental disease may also be expected to increase as the number of very old people in society increases.

Concerning the trends in service provision, the primary responsibility for the health of the elderly will remain with the elderly themselves, and with the family. There is a real dilemma as to how service provision can be organized if only private provision is available. This would serve only the rich and, if there has to be any provision for the great mass of the elderly who will be living in the rural areas, this must be through existing public service provision. Although in principle services are available and accessible to all, in fact services for the elderly are provided through facilities which at present are under-staffed and under-provided with resources and medicaments.

The experience of developed countries of increasing frequency of adverse drug reaction would probably not apply in the developing countries where the elderly get either no medicaments or continue to get traditional remedies. The final comment on service provision is that several countries in the Region have now established plans for the provision of primary health care by the year 2000 and certainly the present pattern of health care provision is expected to change radically by the year 2000.

### 5.7 Impact of development on care of the aged

The impact of development is shaking the roots of social institutions in the developing world, especially the family structure. The trend to urbanization will undoubtedly result in separation of the generations physically, but not for any other reason than because of the practical environmental situation and, even with physical separation, filial piety is likely to remain strong in the oriental situation.

Development has been interrupted by frequent crises in South-East Asia, which have resulted in large-scale migration and population movements which have completely changed family life in certain local situations. Another feature of development which Asia has been unused to in the past is the phenomenon of the working mother, which has resulted in the present generation of children getting less time from their parents than previous generations. The net effect of development to date has been that the rich/poor dichotomy has become even more emphasized.

In China, since 1978, there has been a programme of "four modernizations", where the emphasis is on urbanizing the rural areas: hence the phenomenon of rural to urban migration is not expected in China. The relationship within the family structure will change with the new policy of the single child within the family, although the full impact of this cannot be foreseen. Concerning the development of services in China, the policy is to have a continuing process of educational recycling of health personnel and the expectation is that, within the next decade or two, the quality of service provided will increase considerably. However, the social system in China is rather unique, and there is no anxiety concerning the care which the elderly can receive through this system. The policies are to maintain the present family structures.

A feature of other Asian countries is the migration of young people to the cities from the rural areas and, in this situation, the elderly are left to look after the houses and the farms.

Perhaps, with development, the developing countries might find themselves in a more favourable morbidity and mortality situation compared to the developed countries since the lifestyles of Asians are "healthy". They do not over-eat or drink, as in western countries, and the pattern of exercise through work is likely to continue in the future.

### 5.8 What is development?

Development can be described as a process, some of the characteristics of which are growth of the formal employment sector, growth of urbanization, expansion of education and the acquisition of technology. One of the consequences of the growth of formal employment is that, on retirement, disengagement comes abruptly, both from work and social roles, with the result that the elderly often feel superfluous. A characteristic of societies which move towards individualism is that traditional values of selflessness are lost. Such new individualistic societies are perhaps less

tolerant of the aged person, and particularly of the practice of the aged person being the focal point around which home and family life is organized. In the process of development, the pattern of the elderly representing experience, knowledge and wisdom is replaced by a quite different pattern where technical know-how is valued. The more recently this technical know-how has been acquired, the more valued it is, with the result that the coming cohorts of younger generations with more recent technology are most greatly valued by society. This is a sociological explanation for the youth-oriented culture which has been a phenomenon of the developmental process.

#### 5.9 Preserving the status of the elderly in developing societies

The fact that devaluation of the aged need not necessarily be an accompaniment of development is illustrated by the experience of Japan, which has key importance for the developing world. A recent Japanese sociological study indicates that the sense of responsibility towards aged parents and knowledge about aging are considerably higher among the age group 20-29 years than among the age group 30-39 years.

This sense of responsibility remains when houses or households are separated, and government policies have been directed at maintaining this family cohesion and traditional respect for the elderly. This extends to giving the elderly a meaningful economic role. For instance, the Ministry of Agriculture and Fisheries rents young cattle to old people who raise them and sell them, returning the loans to the Government. In urban areas, the Government has promoted cooperative projects in which old people, as a collective, find a job, do the work themselves and obtain money.

The phenomenon in developed countries of low status being attributed to those working with the elderly is a manifestation of the low status given to the elderly in those countries. The experience in Japan is that, when the elderly have high status, then there is a high status for working with the elderly. This norm of respect for the elderly is also maintained in China through neighbourhood pressure to maintain respect traditionally accorded to the elderly. Strategies for maintaining this cultural attitude have included a Senior Citizens' Week in Singapore when the nation was called to love, understand and respect its senior citizens. Japan has a National Old People's Day. In Hong Kong a Week for the Elderly is held.

Another manifestation of development is that housing design and structures change with urbanization and there is a particular problem of space, with limited accommodation being provided frequently in high-rise buildings. Here, special housing policies need to be directed at facilitating the life of the elderly. However, the general experience is that the elderly do not like living in urban areas but prefer to stay away from urban development because of the difficulties of life for old people in the cities. This makes it particularly important that the social and health services are extended to the rural areas to make sure that the elderly are not disadvantaged by the development process. Indeed, the potential contribution of the elderly to the development of society remains unrealized.

#### 6. Caring for the elderly

Care of the elderly is seen essentially as a nursing function, the key roles being those of health promotion and disability prevention. Firstly, however, the nurse has to get out from the hospital and into the community. However, the problem in developing countries is that there is a dearth of nurses, and even to meet existing hospital staffing ratios there are insufficient nurses. The concept of nursing as a hospital-based service prevails in most developing countries and there is an evident need to have a new type of nurse, who could function effectively both in a community as well as in a hospital setting. For example, it may be appropriate and necessary in some cultures to have male community nurses. Also the emphasis should be on nursing functions, since the name attributed to the person performing these functions may vary according to the situation; for instance, in China, nursing (and other) functions are carried out by barefoot doctors. The principle was supported, however, that a WHO position paper giving a paradigm of the nursing role would be a great help in improving the quality of care that old people receive. The problem is that, in developing countries, the number of professionally trained nurses is inadequate and community nurses hardly exist. Indeed, even in developed countries there is such a shortage of nurses that essential hospital nursing care cannot always be provided on a day-to-day 24-hour basis. In most developing countries, essential nursing functions are carried out by auxiliary nursing personnel.

What is needed is a generalist approach rather than a specialist approach. This is to say basic nursing education should produce a professional nurse with a general orientation who can adapt to either a hospital or a community setting. The lack of professional nursing and community health services in developing countries has led to the practice of nursing by people taken from the community and given short basic training courses. These people can be taught to perform the tasks of disability prevention and health promotion among the elderly, with supervision by trained nursing staff.

The principle of community nurses keeping track of vulnerable groups is feasible in certain countries, such as Hong Kong, where the recommendations of the WHO Expert Committee are implemented in this respect.<sup>a</sup>

In practice the main health workers caring for the elderly are nursing personnel, since they are continually in contact with the elderly. However, the interrelationship of the nurse with the physician and other members of the health team needs to be strengthened. The issue of specialized nursing training had been well investigated in relation to family planning in the developing countries and the experience of this should be kept in mind when further specialized personnel are proposed. A few nurses with specialized skills in health care of the elderly are needed. These would be people broadly trained as nurses but with additional specialized skills. They would be knowledge givers to the broad mass of nurses during general training. However, with young people working in the community there is a risk of irritating elderly people instead of helping them, especially if the socialization patterns of the elderly in rural areas are not understood. The public health nurse who is already working in rural districts in some countries, such as Malaysia, could undertake the function of community care of the aged. The experience in China indicates, without doubt, that for China the best way of having nursing functions performed is through barefoot doctors, since there still is a shortage of professional nurses and, even in China, the development of specialized personnel is a long way off.

A key consideration in defining the role of nursing is the resource allocation for health manpower. If cadres are developed with highly differentiated roles, then there is a risk that such specialized categories will be lost to the country and certainly to local communities, with the result that the considerable capital invested in the training will be lost. Thus the person available in the community is the person who has to be employed in nursing the elderly. Whoever is identified in the community to perform the nursing functions must have skills in health maintenance and in organizing family support. It was agreed that it was the function rather than the profession which mattered, and not the name attributed to the person performing the nursing function.

One particular need that older people express is for traditional medical care, which is often more desirable to them than western medical care. Studies of the utilization of western health facilities in developing countries show gross under-utilization by the elderly. This could be overcome, however, by the adaptation of practices in health institutions which give more consideration to the needs of old people who travel long distances to wait in long queues for care. In developing countries, such as India, Pakistan and Thailand, the main bulk of care would be given through a primary health care network that depends on village or voluntary health workers or barefoot doctors. The functions that such personnel perform have, of course, to be taught and the required skills need to be made explicit. In this respect, the nurse has a role as teacher, a role which a WHO position paper on nursing could help to achieve. In summary, what is required as an objective is better nursing care for everyone.

## 7. Care of the elderly in ESCAP subregions

Full documentation is provided in country specific reports prepared by Working Group participants on present patterns of care, and in general reports prepared by non-participating experts from the region (see Annex II).

The reports below concerning three ESCAP subregions are derived from these country reports. Literature published concerning the care of the elderly from the three subregions is scanty, but reference sources quoted during the meeting are also presented in Annex II in relation to the subregions described below.

### 7.1 Middle South Asia

This is the subregion with the lowest levels of expectation of life at birth, the level for India and Pakistan in the period 1975-1980 being in the range 50-55 years. In India, in the next 20 years, the number of persons aged 65 years and over will increase by 17 million and, by the year 2000, the number aged 80 and over will total 4.7 million. This population aging will take place against a background of rapid urbanization, for the urban population in India is expected to increase by 175% between 1980 and 2000. Large sections of the aged population suffer from health problems which have their origins in socioeconomic causes. Famine and landlessness have already had a serious impact on the elderly population. Nevertheless, diseases of development such as hypertension, heart disease and diabetes are appearing as leading causes of reported death among the older population. A special health hazard of aging is cataract.

<sup>a</sup> WHO Technical Report Series, No. 548, 1974 (Planning and organization of geriatric services; report of a WHO Expert Committee).

The elderly do not comprise a homogeneous group; in India there is wide variation among the scheduled castes and there is a certain class/caste characteristic in aging lifestyles. However, even in poor families, the aging do carry responsibility for the socialization of the children of the family. There are specific problems among this poor majority with regard to their care and living expenses when they cease to work. Studies that are available indicate differences in survival rates in different economic groups in the population.

There is a belief, which is unfortunately perpetuated in the western world, that the extended or joint family system provides the aged with the resources, facilities and transfers which social security systems provide in industrialized countries. This is a myth; the aged in the Third World share with the rest of the family group the problems of inadequate nutrition, drinking-water, housing, health care and economic security.

Medical services are being reoriented to provide a network of primary health care facilities that utilize indigenous traditions to support preventive and promotive health care and which put the family at the centre of care, both for the aged and the non-aged.

The few reported studies from the subregion highlight certain health problems as being characteristic of the aged. "Senility", respiratory disorders, undifferentiated fevers, disorders of the circulatory system, and disorders of the nervous system are recorded causes of death in an Indian census document. A study in Nagpur mentions cardiovascular diseases, infective and parasitic diseases, cancer, digestive system ailments, and respiratory ailments as making up the major "causes" of death among the elderly. Other studies give other data, but they are based on interviews with elderly respondents and not on clinical diagnosis. Apart from the "causes" of death, these studies mention more common complaints, namely: sensory handicaps, hypertension, gastrointestinal diseases, diabetes, arthritis, etc. Medical problems commonly encountered in the elderly in Pakistan are hypertension, heart disease, strokes and diabetes.

No specialized health services exist for the aged. Publicly financed and private general hospitals and private practitioners attend to the health problems of the aged along with the rest of the population. Urban industrial workers are covered by a system of health insurance, but the poor generally depend upon government-supported free services made available through hospitals and clinics.

A limited programme of old age pensions has been adopted by some Indian State governments. Assistance is available only to those who have no relatives to support them.

A number of private charitable "homes" exist in many urban centres to provide care for the indigent old. No listing or count of such institutions is available for the country.

A comprehensive health care system is now being developed in Pakistan and there is progressive growth in the number of health personnel in that country. Free medical service is potentially available to all, including the poor and infirm. Major support has to be provided by the family - an institution which is still intact. Loving care of the elderly is also a religious injunction. Health care of the elderly will receive increasing attention in the health plans of the country.

## 7.2 East Asia

In Beijing, China, the expectation of life has increased from 52 years in 1950 to 69.5 years in 1979. Survival is higher among women and is increasing at every higher age-level among the elderly. Diseases and disorders prevalent among the elderly are hypertension, chronic bronchitis, coronary heart diseases and elevated blood glucose. Sensory loss (of vision and hearing) is also common. Deaths at age 65 years and over were found to have resulted mostly from:

respiratory diseases	- 24%
nervous system diseases	- 25%
cardiovascular diseases	- 22%
digestive system diseases	- 20%
urogenital system diseases	- 5%

Hong Kong has witnessed rapid industrialization, accompanied by an increase in the number and proportion of the elderly, who constitute 10% of the population (elderly being defined as aged 60 years and over).

With regard to health services, there is one geriatric unit and it is planned to provide at least 3 beds per 1000 elderly persons. Day hospital services are available. An elderly person requires on average 14 consultations per year. A community nursing service is being organized and a central health education unit has been established.

The increase of the aged in the population increases the number of consumers of social services, which poses a problem in health financing policies. A 1976 study of 808 elderly persons revealed that:

- 4% of the elderly live in collective households;
- 12% live alone;
- 16% live with another person;
- the rest live with their family.

Those between 60 and 64 years continue to work, though most of them are engaged in low-paying jobs. The approach is to keep the aged as long as possible in the community. However, the 1976 study found that:

- 18% of the elderly are unable to look after themselves;
- 20% have insufficient help when ill.

Three types of residential services for the aged are therefore provided: (a) hostels, (b) homes for the semi-ambulatory and (c) care and attention homes for the physically dependent. Additional services available include community supportive services such as home help, meals-on-wheels, recreation, multi-service centres and home visiting.

Though demographic changes have taken place in the Republic of Korea since 1960, the family-centred orientation of Korean society has not yet changed. Age is still a major status determinant, though probably less so than in the past. The proportion of the widowed among the old has decreased. To be "elderly" is a sociopsychological concept, not merely a biochronological one. At one time, persons of 50 years of age were considered elderly. Today, even at 60, the person may not consider himself old.

Health problems of the aged have not been discussed specifically as an issue in Korea - partly because of improving health standards and partly due to lack of awareness - and no special governmental programmes have been developed for the health of the elderly.

The Korean family has not changed appreciably, neither in size nor in the norms by which it is governed. In urban areas, the old parents may have a separate household, but these are often temporary phases in a family cycle. The problems of the aged, if any, arise primarily from individualism. If this increases, the old may be considered a burden rather than an asset. The elderly also experience a problem in the occupational sphere. An increasing proportion have to go through an out-of-work phase, especially where in some sections retirement may be obligatory at 45 years of age. The fact that the elderly may not have had much education also comes in the way of their continuous employment.

There are important sex variations in respect of survival rates of the elderly. Women survive longer, and they tend to have a lower social/familial status. The problems of elderly men are likely to be very different from the problems of elderly women.

Even in the year 2000, the Korean familial goals may not undergo change. Whether or not problems arise will depend upon whether or not these old values are lost, rather than on mere demographic factors. As individualism increases there will be greater risk of social isolation of the elderly. It is important to identify what aspects of traditional culture can and should be retained.

### 7.3 East South Asia

Malaysian society is characterized by strong bonds of filial duty which helps in providing care to the elderly. If these bonds weaken in the future many problems will arise in respect of the elderly.

The Philippine population is still young, those aged 65 years and over constituting only 3% of the population. However, the absolute number of elderly people is increasing.

A government-funded health delivery programme (Medicare) exists for all age groups and every hospital is required to have "Medicare" beds.

The five leading causes of mortality are: pneumonia, tuberculosis, heart disease, diseases of the cerebrovascular system and malignant neoplasms. With a rising life span, chronic diseases are expected.

Retired servants are entitled to a pension on completion of 25-30 years of service, both in the government and in the private sector. Other old people do not receive pensions.

The elderly poor may be cared for in state and private "homes", where the emphasis is mainly on provision of food, clothing and shelter. There are no special health care units for the aged in the community. The aged go to the same hospitals as the rest of the population, although in a few hospitals there are facilities for rehabilitation of physically disabled old persons. All the needy aged cannot be accommodated in residential institutions due to limited funds being available. The problems of the aged are now gradually receiving recognition from government and from social workers. One noted home for the aged and infirm is "Golden Acres". This is a national institution for depressed, needy or unattached citizens of the country and is an integrated social welfare project of the Department of Social Services and Development.

In the city state of Singapore, the elderly, namely those aged 60 years and over, constitute 7% of the population, although in some localities the proportion of the aged appears higher. Major causes of death among the elderly are heart disease, malignant neoplasms and cerebrovascular diseases.

A study undertaken in 1954-55 showed that every third or fourth household had a person over 55 years. Most of the persons living with the family appeared happy. Hypertension, glycosuria and tuberculosis were among the diseases most prevalent among the aged. Those who lived in vagrants' homes were often eccentric and some were opium addicts. The custom of undertakers being licensed to receive sick individuals in the terminal stages of their illness has been abolished since 1963.

In 1975 there were more than 10 "homes" for the aged. Currently available services for the aged in Singapore include:

- home nursing - a special foundation;
- monetary assistance, home help, and recreation provided by the Red Cross;
- a hospital open to all races - Kwong Wai Shiu;
- care for the semi-ambulant or disabled provided by Villa Francis;
- a home for the aged - Little Sisters of the Poor;
- St John's Home for the Aged.

Additionally, the Government runs two "homes" - one for women and one for men. A recent development is the initiation of a home help service by medical social workers. The Trained Nurses Association provides a paying nursing service for the elderly.

In Thai culture old age is respected and the older generation is well integrated into the family and into society. Persons aged over 60 years have doubled in the last 20 years and at a rate faster than for the population as a whole. This is partly a result of the decline in fertility rate. Thai policy is one of health for all - including the aged. Information on mortality and morbidity among the aged is lacking.

In Thailand 99% of the elderly live in their own families and in community settings. Health care and other welfare services will be developed in an integrated form with a wide range of care alternatives. These services have just begun to be developed and the following are planned:

- free medical care for the aged;
- homes for the aged;
- geriatric units in general hospitals.

However, no systematic study of health needs of the elderly has been undertaken so far. Hence a series of linked activities are sought to be developed in collaboration with WHO, namely:

- an epidemiological study of health of the elderly;
- integration of health care for the elderly as a part of the basic health services;
- developing mechanisms for coordinating governmental and voluntary efforts;
- strengthening of training of health and related personnel;
- setting up demonstration centres in community services;
- technical support to medical institutions for developing special geriatric programmes.

## 8. Conclusion

A regional mechanism for constant review of the situation of the elderly was proposed. This could take the form of a regional panel or "brains trust" with the following functions:

- evaluating various intervention programmes for the elderly;
- promoting research on aging;
- acting as an information centre;
- exchanging ideas;

- ensuring international cooperation in programmes for the aged in developed and developing countries.

Since the problems of the aged within the countries of the region will change markedly over time, any regional panel or committee would have to be established on a long-term basis.

Annex I

DEMOGRAPHIC DATA

Table 1  
POPULATION BY URBAN/RURAL RESIDENCE (IN THOUSANDS)  
1975 AND 2000

Country	URBAN				RURAL					
	1975	2000	Increase		1975	2000	Increase		Percentage	
			No.	%			No.	%	1975	2000
Bangladesh	7 101	34 092	26 991	380	69 481	119 239	49 758	72	91	78
Burma <sup>a</sup>	7 462	13 200	5 738	77	22 384	39 599	17 215	77	75	59
China	208 522	459 268	250 746	120	686 817	730 305	43 488	6	77	61
Hong Kong	3 928	5 936	2 008	51	439	473	34	8	10	7
India	128 341	353 122	224 781	175	490 490	684 083	193 593	40	79	66
Indonesia	24 929	71 489	46 560	187	110 301	150 137	39 836	36	82	68
Japan	83 727	110 670	26 943	32	27 797	18 231	-9 566	-34	25	14
Republic of Korea	16 682	36 237	19 555	117	17 981	14 553	-3 428	-19	52	29
Lao People's Dem. Rep.	376	1 439	1 063	283	2 927	4 287	1 360	47	89	75
Malaysia	3 341	8 393	5 052	151	8 642	11 788	3 146	36	72	58
Mongolia	686	1 700	1 014	148	758	987	229	30	52	37
Nepal	557	2 200	1 643	259	12 177	20 233	8 056	66	96	90
Philippines	15 041	40 912	25 871	172	28 803	45 521	16 718	58	66	55
Singapore	1 667	2 428	761	46	583	667	84	14	26	22
Sri Lanka	3 267	8 142	4 875	149	10 336	11 921	1 585	15	76	59
Thailand	5 618	17 635	12 017	214	35 741	58 426	22 685	64	86	77
Vietnam	9 468	28 867	19 399	205	37 078	50 489	13 411	36	80	64

<sup>a</sup> Revised figures provided by the office of the WHO Programme Coordinator, Burma

Source: World Population and its Age-Sex Composition by Country 1950-2000 (United Nations, ESA/P/WP65, New York, 1980), quoted from WHO/DSI/ESCAP/80.20

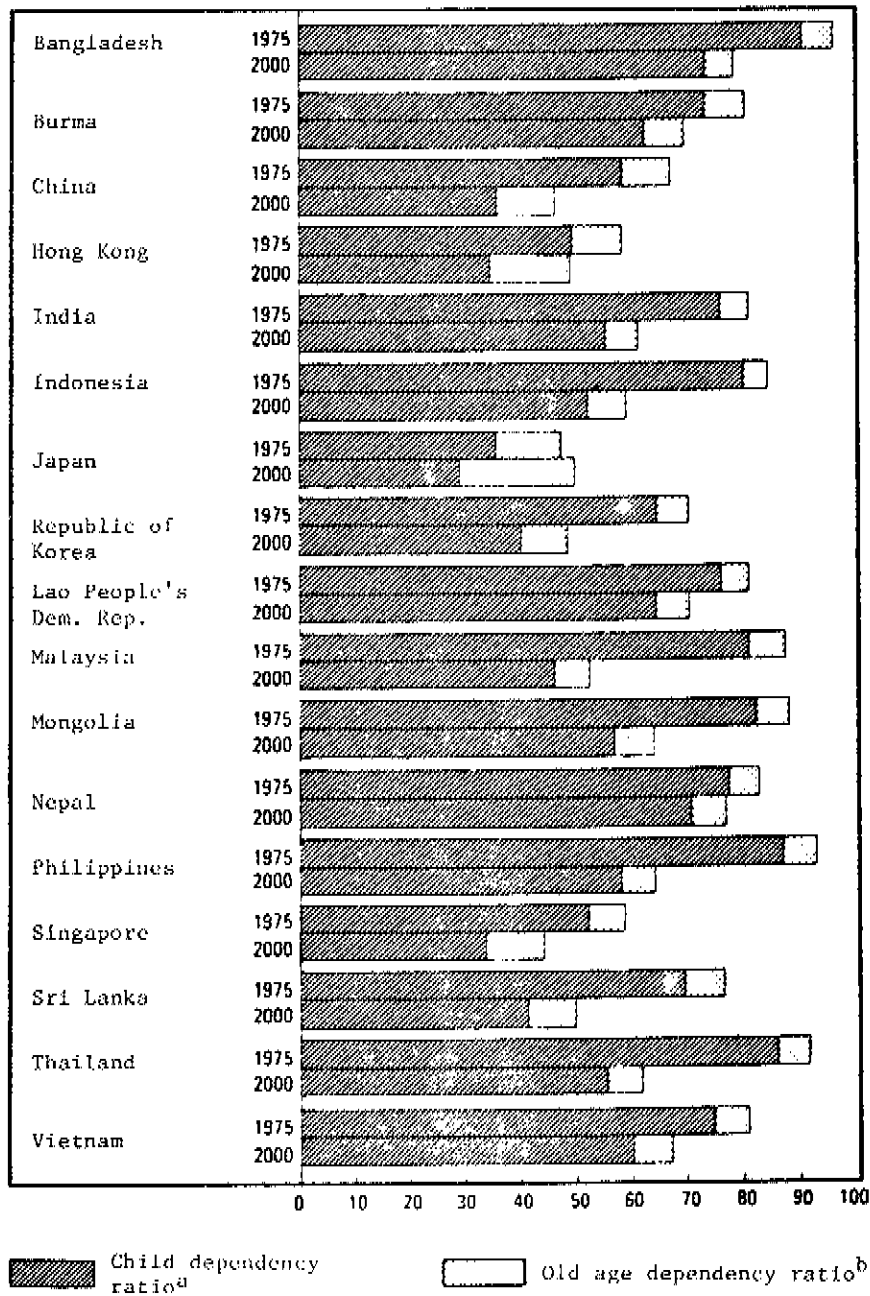
Table 2  
TOTAL POPULATION (IN THOUSANDS) BY AGE IN 1975 AND 2000 FOR COUNTRIES OF SOUTH AND EAST ASIA

Country	<15		15 - 44		45 - 64		≥65		TOTAL												
	1975	2000	1975	2000	1975	2000	1975	2000													
	No.	%	No.	%	No.	%	No.	%	No.												
Bangladesh	35420	63192	27772	78	31214	70414	70414	39200	126	7850	15360	7510	96	2098	4365	2267	108	76582	153331	76749	100
Burma	12768	20193	7425	58	13211	25574	12363	94	4130	6919	2789	68	1131	2422	1291	114	31240	55108	23868	76	
China	312246	291758	-20488	-7	402814	582053	179239	45	132482	230015	97533	74	47795	85747	37952	79	895337	1189573	294236	33	
Hong Kong	1372	1485	113	8	1972	3060	1088	55	784	1218	434	55	239	643	404	169	4367	6406	2039	47	
India	259536	356458	96922	37	269598	508451	238853	89	71579	133965	62386	87	18119	38332	20213	112	618832	1037206	418374	68	
Indonesia	58667	72818	14151	24	58322	110026	51704	89	14842	29260	14418	97	3398	9521	6123	180	135229	221625	86396	64	
Japan	27109	24923	-2186	-8	53679	50578	-3101	-6	21946	35365	13419	61	8790	18037	9247	105	111524	128903	17379	16	
Republic of Korea	13084	13656	572	4	15983	25466	9483	59	4343	8654	4311	99	1252	3015	1763	141	34662	50791	16129	47	
Leo People's Dem. Rep.	1389	2169	780	56	1432	2652	1220	85	392	708	316	81	90	197	107	119	3303	5726	2423	73	
Malaysia	5197	6134	937	18	5092	10372	5280	104	1293	2835	1542	119	401	841	440	110	11983	20182	8199	68	
Mongolia	633	937	304	48	607	1292	685	113	160	346	186	116	46	112	66	144	1446	2687	1241	86	
Nepal	5406	8956	3550	66	5368	10122	4754	89	1578	2551	973	62	381	804	423	111	12733	22433	9700	76	
Philippines	19808	29581	9773	49	18346	40551	22115	121	4360	10371	6011	140	1329	2929	1600	120	43843	83432	39589	90	
Singapore	743	728	-15	-2	1114	1487	373	25	305	660	355	116	90	222	132	147	2252	3097	845	38	
Sri Lanka	5353	5507	154	3	6033	10076	4043	67	1664	3297	1633	98	555	1182	627	113	13605	20062	6457	48	
Thailand	18564	26086	7522	41	17263	37636	20373	118	4296	9349	5053	118	1238	2991	1753	142	41361	76062	34701	84	
Vietnam	19212	28528	9316	49	19721	37242	17521	89	5971	10204	4233	71	1642	3383	1741	106	46546	79357	32811	71	

Source: World Population and its Age-Sex Composition by Country 1950-2000 (United Nations ESA/P/WP65, New York, 1980), quoted from WHO/DSI/ESCAP/80.20

Figure

DEPENDENCY RATIOS FOR COUNTRIES OF SOUTH AND EAST ASIA, 1975 AND 2000



<sup>a</sup> Defined as the number of children under 15 years per 100 population aged 15-64 years.

<sup>b</sup> Defined as the number of persons aged 65 or over per 100 population aged 15-64 years.

Annex II

LIST OF WORKING DOCUMENTS, BACKGROUND PAPERS AND BIBLIOGRAPHIC SOURCES

WORKING DOCUMENTS AND BACKGROUND PAPERS

Asia and the Pacific

The triumph of survivorship, by Dr S.A. Meegama

The contribution of the elderly to society, by Dr M.A. Adiseshiah

Middle South Asia

Health services for the elderly in India, by Dr M.S. Gore

Health services for the elderly in Pakistan, by Dr N.I.A. Khan

East Asia

Some problems in geriatrics, by Professor Cai Ruisheng, Department of Geriatric Medicine, Beijing Hospital, China

Health care of the elderly in Hong Kong, by Dr Ng Yau-Yung

The elderly in the Republic of Korea, today and in the year 2000, by Dr Kwon Tai Hwan

East South Asia

The elderly in Malaysia: a brief overview, by Dr Ezanee Merican

Philippines. A brief analysis on health care of the elderly in the Philippines, by Dr R.I. Talag

Singapore. A brief note on making the environment safe for our senior citizens, by Professor Leong Hon-Koon

Health services for the elderly in Thailand, by Dr Banloo Siripanich

General

AGE 80.1 Health care of the elderly, the role for nursing

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Annex III

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