Rural Aging – a Global Challenge
A report on International Conference on Rural Aging, Charleston, WV, USA, June 2000

The international conference on “Rural Aging – a Global Challenge” took place in Charleston, West Virginia, USA, during four days early in June 2000. It was convened and hosted by the Center on Aging of West Virginia University and sponsored by the World Health Organization, the International Association of Gerontology, and the United Nations’ Program on Aging.

The 1,800 participants heard plenary lectures by international experts on the issues of aging and could choose among 260 presentations within the framework of invited symposia and workshops. The vast majority of those attending came from the USA, but there were also 140 participants from 40 developed and developing countries from all the continents, as well as representatives from international organizations. Participants came from a multitude of professional disciplines: social and behavioral scientists, public health workers, health care professionals, social workers, educators, experts in physical training, administrators, architects, driving safety experts, and technologists.

Conspicuous by their absence from this impressive, truly international and multidisciplinary assembly, were colleagues from countries of Central/Eastern Europe – Croatia, Hungary, Slovakia, the Czech Republic, Poland – except for one participant from Slovenia (H.B., co-author of this report). Their absence may indicate that professionals of these countries are insufficiently aware of the significance of the various dimensions of population aging in general and of rural aging in particular.

We were prompted to prepare this report in the hope of raising the awareness of colleagues from the above countries who are readers of the Croatian Medical Journal.

Population Aging

Population aging refers to changes in the age structure of a population, caused by changes in birth rate, mortality, and migration; the result of these changes is the increase in the relative size of the population age 65 and over. The increase in the number and proportion of older people will be one of the most profound forces affecting society, and particularly health and social services, in the 21st century.

Population aging has been associated with the industrialized, highly developed countries of Western/Northern Europe and North America, where 20% of the entire population is 65 and older.

However, population aging has been occurring in less developed countries as well; this represents a major challenge to public health in countries that are still dealing with basic development problems and where the persistence of poverty creates pressures on already strained systems (1). World-wide, the estimated number of people who are 65 and older is 800 million in 2000, and will increase to 2 billion in 2050. The main increase will be in developing countries.

The process of aging has a significant impact on several dimensions of the development and functioning of societies and the well-being of both older persons and the young population. The most important issues are pension and retirement systems, composition and patterns of participation in the labor force, family and household arrangements, intragenerational/intrafamily transfers and health conditions of older persons (2). All countries, in varying degrees and within different frameworks, will have to cope with the impact of population aging in their public health and socioeconomic agenda. The most important dimensions and challenges posed by the phenomenon of aging are the following.

Demographic Dimension

This refers to a shifting of a society’s fertility and mortality rates; populations begin to age when fertility rates decline and mortality rates decrease at all ages. Generally speaking, societies are considered relatively old when the population age 65 and over exceeds 10% to 12% of the total population.

Countries of Central/Eastern Europe have reached the “being old status”. In Slovenia, 16.2% of inhabitants were 60 and older and 13.6% were 65 and older in 1998 (3). In Croatia, 11.62% of the population was over 65 in 1991 and 12.32% in 1996 (4). In Hungary, the proportion of people age 60 and over was 18.4% in 1980 and 19% in 1990 (5). In the Czech Republic, the proportion of males age 60 and over in 1992 was 19.1% and in Slovakia 20.3% (6). Poland’s population of 38 million – the largest among these countries – is the youngest: in 1990 the proportion of people 65 and over was...
Epidemiological Dimension

In less developed countries, investments in child and adolescent health still represent a priority for public health, whereas the health needs of older adults and the development of services for an aging society are seldom given the appropriate attention. Countries that are in a more advanced stage of demographic transition are recognizing the need of health care for older persons and of aging-related pensions and social-support services in the face of the increased demands resulting from the rapid growth of the older-old (aged 75 to 84) and of the oldest-old (85 and above) population.

Socioeconomic Dimension

The impact of population aging is due to the degree, and – even more so – to the speed of aging. When the ratio of persons over age 15 and younger, relative to those 65 and older, falls dramatically, social and economic structures have difficulty adjusting. A further relevant economic aspect is the composition and dynamics of the economically active population. Also, the increased presence of older people will require goods and services whose availability is currently limited.

Health Care Dimension

This dimension involves important equity aspects. Health in old age is greatly determined by living patterns, exposure to health risks and opportunities for access to disease prevention and health promotion throughout the life cycle. However, the accessibility of comprehensive health care differs across socio-economic strata; there fore, without a national strategy that addresses each of these factors with fairness, the inequities in the well-being and in the quality of life of older persons from different socio-economic classes will become even greater. Since men and women experience different mortality patterns and are affected by different health problems, gender differentials have to be recognized.

Younger and older cohorts, with different income experience differ also in accessibility to resources essential to a healthy life. Further, as pertinent to equity and the health status of older persons is the geographical distribution of the population, with special reference to elderly persons in rural areas; this aspect will be addressed separately.

The challenge then is to reduce inequities and promote healthy aging by considering the difference in accessibility to health services attributable to socioeconomic status, age cohort, and place of residence.

Rural Aging

It is estimated that close to 60% of the world’s elderly live in rural areas. Thus, any reference to rural aging addresses in fact the majority of the world’s older persons.

The distinction between urban and rural is arbitrary and differs from country to country without a standard definition of either term. The concept of “rural” is multidimensional; it reflects contrasts between urban and rural environments, in the health of their population and their use of services, in access to services and amenities, in culture and lifestyle. The contrasts vary in intensity according to social, environmental, cultural, and demographic factors. Special problems of rural areas are the following.

Poverty and Depopulation

Industrialization and globalization of agriculture have profound effects on residence and work in rural areas. The lack of profitability of family holdings has been a cause of rural poverty and has increased migration to urban centers and, consequently, depopulation. This trend is well advanced in industrialized and recently developed countries, too. Old persons are usually the last to move, following their children to urban areas and facing difficult adjustment.

Environment

Lack of safe, piped drinking water and of sanitary facilities for the disposal of sewage and garbage are common. Housing is mostly of low quality and poorly maintained; often there is no electricity and, consequently, lighting is poor. There may be malnutrition. Access to other community ties and services may be difficult because of poor and badly maintained roads, thus compounding remoteness. There may be extreme climatic conditions for parts of the year and exposure to frequent in jury due to hazards of rural life.

Remoteness

In many countries, large numbers of older people live in remote, inaccessible, and isolated areas distant from urban centers, with lack of transport and difficulties in communication. Governments tend to neglect rural communities with deficiencies in their health and social-support systems whereas rural and remote populations lack the political weight for obtaining the same social benefits as people in cities. Rural and remote communities have traditionally been more self-reliant and mutually supportive than urban dwellers, but aging and depopulation are reducing the availability of assistance from neighbors.

Conclusions

The conference was a remarkable event, well conceptualized and planned, and smoothly implemented. It was brimful with valuable contributions from which all participants could learn much. On the basis of its contents, and with some additional information, we would conclude that the increase in the number and proportion of older people in the world – particularly in rural areas – may be one of the most profound forces affecting society, especially in its health and social services, in the 21st century.
Countries of Central/Eastern Europe are already experiencing population aging, which will in them also be one of the century’s most important phenomena. Development of health and social support services needed by elderly persons has been initiated in some of these countries (6,8,9), but further changes and improvements are necessary in order to be able to cope better with the phenomenon.

We hope that this report will contribute to an increased awareness of colleagues who are readers of the Journal, and through them of other health professionals, to health care aspects of the aging phenomenon. Each could assess the needs in his or her field for change and his or her responsibility to initiate it. Issues in which activities could be promoted would be:

(a) Inclusion of gerontology and geriatrics in the generic education and training of all future health professionals as well as in their continuing education.
(b) Requirements for medical undergraduates of course work and examinations in geriatrics.
(c) Creation of opportunities for and encouragement of specializations of physicians in geriatrics.
(d) Training and education of primary care teams in the knowledge, skills, and attitudes required for managing health problems of older people, particularly in rural areas.
(e) Development of public services for the elderly, such as geriatric departments for acute and subacute care in general hospitals, addition of long-term beds, further expansion of community, and home-care services.
(f) Education and training of informal carers (family members and others) in the care of the partially dependent elderly person.

Colleagues could also attempt to attract the interest of political leaders in issues related to aging in general and rural aging in particular, especially in developing services needed. The latter would require a reallocation of resources, which is one of the major challenges for public policy in an aging society.

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