Policy Brief

Healthy and Active Aging: The Panacea to Reap the Longevity Dividend

Key Messages:

- *The older population of Bangladesh are rapidly increasing.*
- *The issues related to healthy and active aging concept should be introduced to all levels of education and social system as life-course perspectives.*
- *Ageism needs to be eradicated by emphasizing aging-related morality and responsibility in our education and social system.*
- *Healthy life expectancy of the older population should be improved by increasing their active participation in different socio-economic activities to reap the second demographic dividend.*

Background:

Bangladesh is rapidly moving towards an aging society due to the demographic transition. The percentage of the older population in Bangladesh is currently 8.0%, which will increase to 21.9 % by the year 2050[1]. At present, Bangladesh has more than 13.1 million population who are over 60 years[1]. It should be noted that there are more than 150 sovereign countries and territories in the world whose total population size is smaller than our older population size[1].

These huge numbers of the older population have created the window of opportunity for the second demographic dividend, and possibly it will work as a foundation for the third demographic dividend as the country is approaching the end of the first demographic dividend. The second and third demographic dividends are also known as the Longevity Dividend, which will not come automatically; instead, the country needs significant investment to achieve these. A country's realization of the second demographic dividend depends on how well it anticipates and organizes support for its older population through ensuring active aging and healthy life expectancy. In this context, this policy brief will highlight some calls for actions for reaping off the Longevity Dividend through ensuring healthy and active aging.

Data Sources:

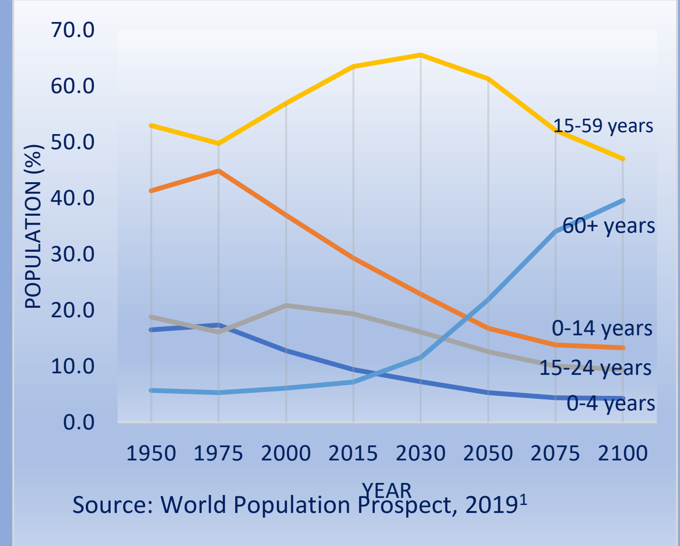
This policy brief mainly utilized the data of the Study on Older Population in Bangladesh (SOPB)[2], which was conducted by the Department of Population Sciences (DPS), University of Dhaka. It has also utilized data of the Report on Bangladesh Sample Vital Statistics[3], published by the Bangladesh Bureau of Statistics and the World Population Prospects 2019[1] published by the United Nations Population Division.

Key Findings:

Healthy Life Expectancy

- The life expectancy at birth has increased to 72.6 years in 2019, and women are living 3.1 years (women: 74.2 years and men: 71.1 years) more than men.[6]
- There is a big gap between life expectancy (LE) and healthy life expectancy (HALE); HALE is only about one-third of the LE among the older people.
- Women have relatively less HALE than men though women have more life expectancy than men.

Figure 1: Population of Bangladesh by Age-Structure



Source: World Population Prospect, 2019[1]

What is First Demographic Dividend?

The economic growth potential that can result from shifts in a population's age structure, mainly when the share of the working-age population (15 -64) is larger than the non-working-age share of the population (0-14 years, and 65 and older).

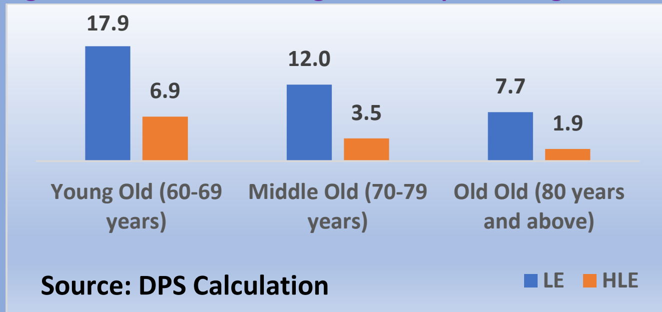
-United Nations Population Fund, 2016[4]

What is Second Demographic Dividend?

The second demographic dividend is associated with the increasingly aging working population, which results in increased production as the strengthened group of older workers strive to build assets to have a more financially comfortable retirement. The second demographic dividend, which increased capital accumulation, is larger than the first demographic dividend.

--Lee & Mason, 2006[5]

Figure 2: LE and HALE among Older People in Bangladesh



- Multimorbidity – having more than two diseases and disability is one of the reasons for this high gap between life expectancy and healthy life expectancy.

Health Status and Health Care Utilization

- Fifty-eight percent of older people reported that they had overall good health.
- The SOPB conducted by the DPS has found that 55.3% of older people had multimorbidity.
- The SOPB also found that 56.6% of older people had at least one disability condition, while 16.9% had two disable states.
- Nearly all (97.5%) older people had received treatment or took medicine for diseases or illnesses.
- The majority (71.9%) had received treatment from the private sectors (pharmacy-79.9%, private doctors chamber-52.7%, and private hospital-13.6%) while only 27.3% had received treatment from the public sector (Upazila health complex-19.5%, district hospital-12.7%, medical college hospital-10.9%, community clinic-4.9%, and Union health and family welfare center-4%).

Health Index

- Overall, 68.5% of older people had better health, which significantly varied by age, household head, sex, marital status, education, wealth, and division.
- Young-old older (60-69 years) people (72.3%) had better health than the middle (70-79 years) old (66.1%) and old-old (80 years and above) older people (55.6%).
- The older people who were a household head had 9% better health.
- The older men (70.9%) had a higher health score than older women (66.6%).
- The currently married older people had better health than who were either widow/widower or divorced/separated/never married.
- The older people who were having an education higher than the secondary level had better health status than those who were non-educated.
- The older people who were having an education higher than the secondary level had better health status than those who were non-educated.
- The older people from the wealthiest households also had a better health status than that of the poorest.
- The older population from the Rajshahi division had higher health status than the rest of the divisions.

What is Healthy Life Expectancy?

Healthy life expectancy is the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury. It considers disability weights to compute the equivalent number of years of good health that a person can expect.

-World Health Organization, 2006[7]

What is Active Aging?

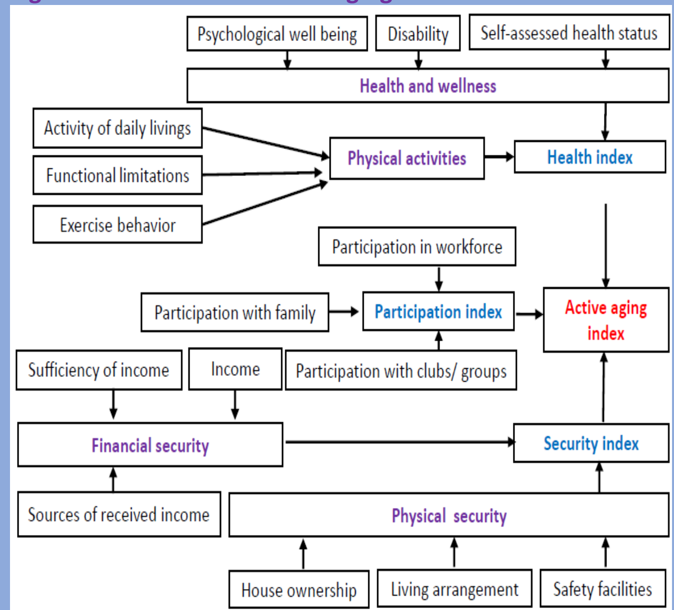
Active aging is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. The word "active" refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force.

-World Health Organization, 2002[8]

Measures of Active Aging

The active aging as defined by WHO has three components: health, community participation and security. These three components have a total of 15 indicators: six indicators for health (three indicators for health and wellness, and three indicators for physical activities), three indicators for community participation, and six indicators for security (three indicators for financial security and three indicators for physical security).

Figure 3: Measures of Active Aging



Source: Thanakwang and Soonthorndhada, 2006[9]

Community Participation Index

- Forty-two percent of the older people were engaged in either paid or unpaid work.

- Eighty-eight percent of the older persons had provided support to family members (e.g., food supply, housekeeping, and childcare).
- Only 9% of the older persons had taken part in activities organized by various social and community groups.
- Overall, only 46% of older people had active community participation, which significantly varied by age, household head, sex, marital status, education, and division.
- The higher the age, the lower the community participation was observed.
- The older people who were household heads had 21.2% higher community participation.
- The older women had 13.2% lower community participation than that of men.
- Married older people had 15.1% higher participation in the community than a widow/widower or divorced/separated/never married older people.
- The older people who had higher than secondary education had 19.3% higher community participation than that of non-educated older people.

Security Index

- One-third (34%) of the older persons had financial security. The financial security included the following three indicators: had some income, perceived the income was sufficient, and had at least one source of income.
- Seventy-seven percent of older persons had physical security. The physical security index included the following indicators: ownership of the dwellings, living with family members or others as co-residence, and having safe toilet facilities.
- Overall, 60.8% of older people had security, which significantly varied by age, household head, sex, marital status, education, wealth, division, and place of residence.
- The older people who were a household head had 16.1% higher security.
- The older men had 21.6% higher security than that of women.
- The older people who were currently married had 12.5% higher security than who were either widow/widower or divorced/separated/never married.
- The older persons who had higher than secondary education had 23.5% better security than that of non-educated older people.
- The older population from the wealthiest households had higher security than that of the poorest households.
- The older population from the Chattogram division had higher security than other divisions.
- The older populations from rural areas had 3.8% higher security than urban areas.

Active Aging Index

- Overall, 58.4% of older people had active aging, which significantly varied by age, household head, sex, marital status, education, wealth, division, and place of residence.
- Young-old older people (61.0%) had higher active aging than the middle (57.7%) and old-old (48.1%) older population.
- The older people who were household heads had better active aging than that of non-head of households.
- The older men had 13% higher active aging than older women while currently married older people had 11.8% better active aging than that of the widow/widower or divorced/separated/ never married older people.
- The older people who had higher than secondary education had 16.9 % higher active aging than the older people who were non-educated.
- The older population from the Chattogram division had higher active aging than that of other divisions.
- It was found that healthy life expectancy and active aging were strongly and positively correlated (r=0.84). That means the older population who were enjoying active aging were also enjoying healthy life expectancy, which is a precondition of reaping the second demographic dividend.

Call for Actions

- The issues related to active aging should be introduced appropriately to all people considering the issue as life-course perspectives. People's awareness and perspectives toward older people (for example, ageism) should be altered by including aging-related morality and responsibility in all levels of our education and social system.
- The accessibility of older people towards quality health care facilities needs to be increased by establishing a geriatric corner in all primary and tertiary health care centers through ensuring the provisions of geriatric medicine specialists, psychiatrists, and physiotherapists at a subsidized rate.
- As a short-term goal until a geriatric corner has been established in all primary and tertiary health care centers, specialized training programs regarding older people's healthcare-related issues should be introduced for drug sellers and pharmacy owners, as nearly 80% of older people had received health care services from the pharmacies.
- The initiative should be taken for the inclusion of gerontology and geriatric medicine-related issues in the academic structure of the MBBS program and introducing a post-graduate medical education, i.e., MS or MD, in geriatric matters.
- Steps should be taken to introduce healthy life-related issues in the school curriculum from the very

beginning of education life so that our population receives lifelong training on how to be active in every stage of life.

- The older women have higher life expectancy but lower healthy life expectancy. Thus, specific interventions should be taken for older women to reduce their morbidity and disability-related burden.

References:

1. United Nations. (2019). *World Population Prospects 2019*. Department of Economic and Social Affairs. Population Division. Volume I: Comprehensive Tables (ST/ESA/SER.A/426). Available from: https://population.un.org/wpp/Publications/Files/WPP2019_Volume-I_Comprehensive-Tables.pdf.
2. Department of Population Sciences. (2019). *Study on Older Population in Bangladesh.* Dhaka: Department of Population Sciences, University of Dhaka and United Nations Population Fund, Bangladesh.
3. Bangladesh Bureau of Statistics. (2015). *Report on Bangladesh Sample Vital Statistics 2014.* Dhaka: Ministry of Planning, Government of the People's Republic of Bangladesh.
4. United Nations Population Fund. (2016). Demographic Dividend. Available from: https://www.unfpa.org/demographic-dividend.
5. Lee, R. & Mason, A. (2006). What Is the Demographic Dividend ? *Finance & Development*, *43*(3), 1–9.
6. Bangladesh Bureau of Statistics. (2020). *Report on Bangladesh Sample Vital Statistics 2019.* Dhaka: Ministry of Planning, Government of the People's Republic of Bangladesh.
7. World Health Organization. (2006). Health Status Statistics: Mortality. Available from: https://www.who.int/healthinfo/statistics/indhale/en/.
8. World Health Organization. (2002). *Active Ageing: A Policy Framework.* Geneva, Switzerland: WHO.
9. Thanakwang, K., & Soonthorndhada, K. (2007). Attributes of Active Ageing among Older Persons in Thailand: Evidence from the 2002 Survey. *Asia-Pacific Population Journal, 21*(3), 113-135. https://doi.org/10.18356/5e5fdd09-en.

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