Not a disease: a global call for action urging revision of the ICD-11 classification of old age

The inclusion of old age in the 11th revision of the International Classification of Diseases (ICD-11) under general symptoms (code MG2A) and in the causality section of XT9T,[1] has been justified by arguing that old age brings about several biological changes of vulnerability.[2] We argue that simply equating old age as a disease in the ICD-11 is potentially detrimental and deleterious from clinical, research, and humanitarian points of view, and propose alternate productive solutions.

Most human beings hope to enjoy a long, safe, healthy, and relatively happy life. Ageing is globally accepted as a normal human attribute and longevity as a privilege. Although chronological age is a known risk factor for many diseases, it is evident that chronological age per se is phenotypically very heterogeneous with enormous inter-individual variability that increases with increasing age.[3] Consequently, chronological age is of limited use for diagnosis, prognostication, and treatment guidance. Additionally, age by itself is of limited use for the assessment of population health, for the evaluation of initiatives designed to promote healthy aging, and for health or social care planning. Ageing might predispose to some chronic medical or mental health conditions with other factors playing a much greater role in the disease causation than age alone. On the positive side, aging confers attributes such as a greater sense of satisfaction, greater resilience, subjective well-being and wisdom. It is evident that various psychiatric illnesses such as bipolar disorder, schizophrenia, panic disorder, and obsessive-compulsive disorder are much less prevalent in old age than in young age.[4] In fact, Isaacowitz and Smith observed that age had no predictive value on positive or negative affect in older adults.[5] Thus, considering chronological age as a sole cause for diseases might be largely inaccurate and misleading. The interplay of biopsychosocial factors is undermined by this causal notion of biological ageing, especially for psychiatric illnesses.

The risk of the current stance on ageing in the ICD-11 is the reinforcement of the widely prevalent ageistic beliefs in society as well as the mental health and medical professionals. As it stands, older adults are often at a socioenvironmental disadvantage in terms of equality in health-care provision,[6,7] and considering age as a disease will potentially magnify this. If age alone is presumed to be the cause of a disease, other factors that might precipitate or perpetuate those diseases might not be evaluated thoroughly, resulting in incomplete management. Additionally, the current classificatory system endorsed in ICD-11 does not enable reporting of the physical and cognitive functions and cumulative effects of diseases. Thus, the overall categorisation of disorders is far from being comprehensive. Moreover, the societal marginalisation and discrimination of older adults because of their age might worsen with the validation of the ageistic beliefs. The COVID-19 pandemic has affected older people in many ways, biological vulnerability being just one of them.[8] Especially in low-income and middle-income countries where the existing mental health infrastructure is insufficient, older patients are facing several barriers to an adequate health care. Exclusion of other possible causal factors from older peoples illnesses just by virtue of their age might lead an inappropriate triage, further escalating the issues faced by them. In the wake of the COVID-19 pandemic, flagrant violations of older persons' human rights have deservedly led to heightened global attention and societal sensitivity to the topic of ageism. This ageist approach must be kept in mind as we deliberate on the topic of including old age in the ICD-11 as a paradigm. A critical situation has been created by the dual pandemic of ageism, with one out of two people being ageist,[9] superimposed on the wounds inflicted on older people by the COVID-19 pandemic.[10] The proposed inclusion of old age in the ICD-11 is central to this crisis, fraught with challenges, and bound to create unintended negative consequences.

Frailty is a much more homogeneous and better-defined clinical entity, which unfortunately robs some older people of the opportunity of longevity, derailing the healthy ageing process. As scientists, we must try to understand the determinants of frailty more clearly and including it in our lexicon of diagnosis would help elevate its importance for clinicians, academics, and researchers, and to benefit society.

A way to move forward from the purely disease-based model of reporting to one which incorporates

both disease and holistic elements is to develop the reporting of frailty in the ICD classification system. We propose that frailty should be included as a clinical disorder instead of old age. Frailty is predisposed by old age and cumulative physiological decline, but not a surrogate marker for old age. Frailty incorporates both functioning and vulnerability, and is more predictive of adverse outcomes like mortality, response to treatment, need for institutionalisation and increased use of health-care resources than chronological age alone.[3,11] Although chronological age is a known risk factor for many diseases, it is evident that chronological age per se is phenotypically very heterogeneous with enormous inter-individual variability. Frailty is a much more homogeneous and better-defined clinical entity, which unfortunately robs some older persons of the opportunity of longevity, derailing the healthy aging process. Frailty is also determined by several factors, including biological and socioeconomic ones. Thus, a timely diagnosis and comprehensive management of frailty can go a long way in preventing morbidity and mortality in older adults.

In view of these shortcomings posed by the ICD-11, ageing and human rights groups and national and international organisations have raised their objections against the inclusion of old age under general symptoms in the ICD-11. The bottom-line is essentially the removal of blanket terms such as old age or ageing as a diagnostic or causal entity. ICD is regarded as a global standard by professionals and is held as an invaluable resource on mental illness diagnosis. The use of the term old age in this book is bound to cause confusion in the clinic and will detract from the treatment of diseases of old age. The unintentional consequence of such a strong term in such an influential reference guide would be to make disaggregation and surveillance of those diseases even harder, making older persons more invisible and voiceless. The use of the term old age would empower the anti-ageing industry, which is worth billions of dollars per year globally with the promise of eternal youth, an irresistible yet futile concept.

Apparently, the ICD teams' intention to include old age in ICD-11 is not to make old age equivalent to disease, but to highlight the pathophysiological vulnerabilities that arises out of ageing. However, that is how it is being interpreted by an overwhelming number of people (professionals, civil society organisation members, and the public at large). Hashtags such as #OldAgeIsNotADisease have been created to raise public awareness and protest against this possibly ageist classification of old age. These hashtags are soon to be translated into Spanish, French, Portuguese, and German. The president of the International Association of Gerontology and Geriatrics has also manifested his views criticising the inclusion of old age as a pathological criteria in the ICD-11 and is requesting all national societies to do the same. National Academies of Medicine are being mobilised and so is the World Medical Association. Medical students' societies have also expressed their views. The media are responding with great interest.

We strongly suggest that WHO consider revising the proposed ICD-11 classification because old age is an ageist term and with the caveats outlined here it should therefore not be introduced as a concept in the ICD-11. This statement echoes the voices of various national and international psychogeriatric as well as gerontological associations including the section of Old Age Psychiatry at the World Psychiatric Association. We advocate for the removal of old age from the proposed ICD-11 and suggest instead considering inclusion of frailty as a concept, which is much more evidence based.

We declare no competing interests.

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