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PROBLEMS OF AN AGEING POPULATION*

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The fact that the authorities responsible for the planning of this joint meeting of the British and Canadian Medical Associations should have chosen ageing as an appropriate subject for a plenary session is evidence of its topical importance, its geographical spread, and its implications for the future. The point, however, deserves to be made at the very outset that it is grossly unfair to the old people themselves to regard their age purely as a problem for society. To do so would be to forget their own massive contribution to the maintenance of our social structure. To make but two points: in general, they make every effort to preserve their own independence, while the contribution made by the older woman to the domestic life of the community needs only to be stated to be realized. Indeed, though official old age begins at 60 for women and at 65 for men, it is broadly true to say that the problems of ageing that are causing anxiety to our present society derive in the main from those beyond the age of 70, for until then individuals tend, by and large, to be donors rather than debtors to society.

The changes in population structure can be presented only in the broadest outline, and, in any case, they are well known. In a community with unchecked fertility and mortality rates, only the exceptional individual attains the age of 65, and so the proportion of old people is low. In Ceylon the proportion of elderly people was 2.0% in 1881 and had risen only to 3.2% by 1951 (Durand, 1955). Most communities seem able to carry without undue difficulty the stresses imposed by old age at this level. By contrast, there were in 1954 six countries in Western Europe whose population contained 10% or more of old people—and at this level the stresses that are imposed on the community by its elder citizens become suitable matters for public discussion. In the countries mainly concerned—for example, Belgium, France, Great Britain, Sweden—this change in population structure depends on the simultaneous effect of two independent processes, based on our modern ability to exercise some control over both fertility and mortality rates.

By our control over certain infectious and other diseases we have greatly increased the expectation of life, and so allowed more and more individuals to reach the old-age group. This by itself would merely increase the total population, but these same countries have also seen a decline in birth rates since the second half of the last century. A smaller percentage of newborn of necessity increases the proportion of those of greater

age, and causes the well-known bulge in the population pyramid. One important social effect of this state of affairs is that fewer children are available to care for their old people, and indeed it has been said that in Great Britain some 25% of our old people are without this source of care (Titmuss, 1955).

In other countries a further factor influencing population structure is the presence of either immigration or emigration. This is of no great numerical significance in Great Britain, but the emigration of its younger citizens is one reason for the high proportion of old people in Eire, and in the opposite direction the immigration of young people may help to keep the proportion of old people down. The Government of Canada in a forecast of future populations publish two sets of tables, one based on no immigration and the other on a net immigration of 75,000 per year (Royal Commission on Canada's Economic Prospects, 1957). These changes in population structure are at their greatest in those countries of Western Europe which were the first to use the techniques of modern science to lessen both their fertility and their mortality rates; but other parts of the world are steadily becoming affected. It is not without significance that Japan, the first of the great civilizations of Asia to adopt Western modes of life, now has two recently formed societies devoted to the study of old age.

Future Trends

It is important to remember that these changes are still in operation, and therefore make all forecasts of the future uncertain. So far as Great Britain is concerned, the immediate future will surely witness a great increase in the number of old people, though the actual situation may prove to be much better than some of the gloomy forecasts of recent years have suggested. In 1956 the Parliamentary Secretary to the Ministry of Health stated that the 5 million people in this country of retirement age might—according to some estimates—have increased by 1977 to 9½ million (Hornsby-Smith, 1956). Taken by itself this would indeed be a daunting prospect, but its effects may well be mitigated by the increase in the birth-rate of recent years, for whereas it takes 65 years to grow an old man, it may take less than 20 years to grow someone capable of looking after him in his old age.

The most important trend at present would seem to lie in the internal structure of the old-age population itself, for whereas 20 years ago more people were just reaching the beginning of the old-age period, now more and more are pressing on to its further end,

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and we are therefore getting more and more very old people. This change is due to the control by antibiotics over the acute and killing respiratory infections of old age. The social consequences of this improvement in old-age mortality are enormous, and more particularly so since, as might be expected, it is the old female rather than the old male who reaps the benefit of this improvement in mortality, and if there is one fact more than another in the medicine of old age which is well established, it is that, in spite of their better mortality rates, old women have a much higher morbidity rate than men. A substantial increase in the number and proportion of very old women could indeed tax our resources. At the present time it has been estimated that some 13% of the men and 17% of the women over 65 are aged 80 and over. It is at this time of life that individuals tend to require medical, nursing, and domestic help from the community, not so much as a temporary support but as a permanent requirement for their survival. It is at these ages that such really senile phenomena as mental deterioration, absence of control over the upright posture, and gross physical weakness become increasing problems.

In Great Britain these changes in population structure are taking place within a social framework that has lost its old stability and is undergoing changes which amount to a social revolution. Some of these have a considerable, if indirect, effect on the ease with which the community can shoulder its responsibilities to its older citizens. The revolution in housing, with the replacement of the old streets of terraced houses by tall blocks of flats, housing estates, or even new towns, makes it more difficult for children and their parents to follow the old-fashioned and favourite custom of living close together but independently. All inquiries have agreed that this is the way the two generations have preferred to help each other. This was the case in the Wolverhampton survey, where no less than 10% of old people had children living in the same street (Sheldon, 1948) and the same state of affairs was demonstrated in the inquiries made by Mr. P. Townsend (1957) in Bethnal Green. Another social change of great importance is the growing employment of women, which may make it more difficult for a woman to find the time necessary to care for an aged relative.

With both population and social structure in a state of flux, one has to consider the problems of ageing within the fixed framework of policy. In Great Britain the official object is "to aid elderly people to live in their own homes as long as is possible," and the Guillebaud Committee supported this policy by saying "the first aim should be to make adequate provision for the treatment and care of old people in their own homes." This is beyond any doubt the right policy, and derives an added strength from the fact that it is what the majority of old people themselves desire. Great Britain is, I think, a pioneer in this respect, but, laudable though the policy may be, success will certainly not be achieved by its mere announcement.

Change in the Problems

Throughout the whole period there is a subtle but continuous change in the character and relative incidence of the different problems presented by old age. It is, nevertheless, convenient to make an arbitrary

division of old age into two periods—those on each side of the middle seventies—provided that we remember the extent of individual variation in the rate of ageing, and that 75 is a purely arbitrary mark inserted into a continuous process. It is, however, broadly true that in the earlier period the majority actively desire, and are still able to lead, independent lives—and clearly all our efforts should be directed towards the preservation of this state of affairs. After the middle seventies, on the other hand, independence becomes more difficult, and as the years increase, particularly in the eighties and over, an increasing proportion of old people need support by the community, which may often be total—as an essential condition for the preservation of their existence. Just as in a symphony a theme may gradually develop from a muted announcement in the background until in a steady crescendo it rises to complete domination, so in the continuous progress of old age the theme of custodial care, which is barely relevant to those in their sixties, ultimately comes to dominate the anxieties of the community for those in extreme old age.

The Earlier Period of Old Age

Our first problem applies particularly to the earlier age group, and is that of enabling them to maintain their independence for as long as possible, which in turn raises further problems in relation to their physical and mental health and their domestic state. So far as physical health is concerned, it may be said at once that enormous benefits have flowed from the provision of spectacles and hearing-aids under the National Health Service, and a further immense contribution to the usefulness of old people will without doubt follow from the provision of chiropody services, for the state of our civilized feet is a major challenge to preventive medicine. The preservation of health in this age-group is of paramount importance, and may well require considerable extension of our hospital services by such methods as that of the day centre.

The "Meals on Wheels" service is of great value, for an insufficient or inadequate diet in old age may lead to a deficit in mental as well as physical vigour. The mention of this service, which is essentially a voluntary one though it may have official assistance, raises a further problem which is always present in endeavours to help old people at home—that of the discovery of those who most need help. This is a very real difficulty, and it raises the question of the development of a service of "Good Neighbours," who from their own local knowledge could assist in the recognition of need. This is of even more relevance in the maintenance of mental than of physical health in the elderly; for loneliness is a potent inhibitor of mental vigour and stability in old age, its possibilities of relief by such voluntary services as visiting or the use of clubs are well-known, and the main problem is the discovery of those who most need it.

Another deterrent to mental vigour in this earlier phase of ageing is the sense of uselessness—which particularly applies to men compulsorily retired at a fixed age. This raises the matter of the employment of the elderly—it cannot yet be said that the problems of employment, having regard to the needs of both the younger and the older generations, have yet been solved.

The need to combat the sense of being "on the shelf" is well recognized, and the big problems of the use of leisure and of education for retirement are now, at any rate, well recognized and under increasing examination.

So far as domestic independence is concerned, the elderly themselves are actuated throughout by the desire to remain independent; during this earlier phase they contribute over 60% of their own maintenance, the balance being mainly supplied by younger relatives. Problems that arise are those of sufficient housing accommodation suitable for old people, of which there is still a considerable shortage, and of its best design and arrangement—whether as scattered units or in groups with a warden in attendance—and of so arranging matters that children and their parents can live close to one another. Nevertheless, there are many old people in this group whose independence is contingent on the provision of further domestic help—available in its various forms both from local authority and from voluntary services. Apart from the difficulties of discovery, the width of the support required—which may involve laundry services—raises further problems.

The Later Period

If we now apply the same points of view to the later period of old age—beyond 75—we uncover a very different set of problems. We now find ourselves faced with an increasing amount of breakdown in health, much of which is, in the light of our present knowledge, both unpreventable and apparently inevitable, imposing a special stress on the community by virtue of its long duration. It is a commonplace observation nowadays that the wards of hospitals for acute cases are themselves becoming increasingly "geriatric" owing to their increasing intake of very old people. In certain departments of medicine, where age is particularly apt to cause breakdown, the incidence may be especially high. The eye hospitals, for instance, have to cope with increasing numbers of old people presenting with cataract or senile degeneration of the macula; the accident and orthopaedic departments have to meet an increasing challenge from the old people whose osteoporosis combined with loss of postural control has led to a fracture, particularly of the neck of the femur. In the women's medical ward of the Royal Hospital, Wolverhampton, the proportion of the total admissions made by women aged 70 and over rose steadily from 3.9% in 1948 to 10.4% in 1957, and for the first half of 1959 was no less than 12%.

The very presence of these problems in physical health serves only to emphasize the importance of the problem of social health at this time of life, in the absence of which the discharge of a locally cured but constitutionally or mentally enfeebled old person may prove exceedingly difficult. This in turn creates a vicious circle, increasing the pressure on accommodation in acute departments whose size was originally determined in relation to a much smaller load. The increasing duration of the period of final incapacity, which is taking place under our very eyes and is a direct consequence of the increase in the numbers of very old people, raises a further problem. It is that of attempting to define the indefinite in the interests of administrative tidiness; and the hope of discovering the correct authority to provide custodial care for an enfeebled old person has led to the creation of a special term—the

"frail ambulant." In general, the greater the age the greater the difficulty of such simple classification, and the less likely is it to be continuously valid. Though a verbal categorization of the varying states of old age may well be essential for administrative purposes, it underlines the importance of flexibility and human understanding in the management of individual problems.

Domestic Aspects

We now come to the greatest problems of all, those involved in the domestic aspects of the policy of Great Britain, that of enabling as many of our older citizens as possible to spend the evening of their lives at home. From what has already been said, it will be clear that the great majority of those in the later period of old age will need help—some intermittently, some continuously, and some only terminally. It is also certain that for many of the old people in the later age-group such help will need to be institutional; for the percentage of those capable of completely independent existence rapidly diminishes at the same time that the percentage lacking effective domestic contact with relatives increases.

The three main types of domestic structure each raise problems of their own. (1) The isolates—old people lying entirely alone without effective human contacts. These people, when in need, inevitably establish a prior claim on the resources of the community—whether institutional or domestic—and so leave less available for others. At the time of the 1951 Census two-thirds of hospital beds for the elderly were occupied by single and widowed or divorced people (Abel-Smith and Titmuss, 1956). (2) In some ways the problems raised by the semi-isolates are even greater. These are the old people living in pairs—such as husband and wife or two sisters—whose independence is based either on the united efforts of both or on the continued health of one partner. When illness strikes, the household collapses and the community may have to carry two individuals, often under circumstances of much emotional difficulty. In fact, the hospitals of the future may have to provide married quarters for their aged patients—as they now do for their residential medical staff. (3) Much the largest group is that of the old people who derive help from the family.

The main burden in the past has always been carried by the family, and is still so carried, and the role of the family in relation to old age therefore needs close consideration. It is commonly said nowadays that children are no longer so willing to look after their parents, and that with the advent of the Welfare State they are only too happy to transfer the burden to the community, and in general that we are witnessing an abdication from the responsibilities of kinship. In my judgment it is more than doubtful whether this is really true. We should bear in mind that as recently as 1946 nearly 8% of the old people were laying an almost impossible strain on the lives of their younger relatives—especially on daughters. Not only was the community quite indifferent to the presence of this sizable volume of sweated labour in their midst, but the actual volume was some three times as great as the accommodation available in public institutions. A refusal of help by a section of this size could well account for the present anxiety. Further, the housing changes and the greater employment of women have made the work both of the immediate and of the extended family more difficult.

Probably, however, the strongest indication that the ties of kinship are still operative lies in the fact that the community is able to manage at all, for a real abdication by the younger generation from the care of their old people would completely submerge our present resources.

This leads to an urgent problem—that of raising the family to a position of recognized partnership, for the family is indeed the dominant partner in the enterprise, and it is only when relatives are absent, as in the case of the isolate, when they fail, or when the burden is too great for them that the community services become necessary. This has immediate relevance to the stresses now imposed on the services in hospitals for acute cases, which have already been mentioned. It entails the elevation of early and adequate consultation with the family into a position of prime importance in the management of acute illness in an old person.

A Social Problem

In old people physical or mental illness is as much a social as a technical problem, and in the future this point of view will need to be recognized as of the greatest importance to the hospital services. Only too frequently, when an old person is admitted for an acute illness, the relatives are not brought up against their responsibilities until a relatively late stage in the illness—usually when discharge home is suggested. This may happen after various domestic changes have been made at home, and then, when the approach to them is made, as it almost invariably is, by someone in a position of secondary authority—the whole set-up is conducive to an atmosphere of rebellion. The response might have been different had they been seen at the outset by someone—such as the doctor in charge, whose authority they accept. The encouraging experience of the more progressive geriatric centres, where the enlistment of the children's support is regarded as a matter of primary importance, shows what can be done. It need hardly be added that in this field the general practitioner plays a part of fundamental importance, and that to a large extent the success of a geriatric unit in hospital hinges on his co-operation in the domestic care of old people. It should be borne in mind that the final illness of an old person may not only be prolonged but also have ups and downs.

It is becoming increasingly recognized in geriatric practice that to obtain the loyal assistance of the family two measures are necessary: (1) the opportunity of an actual interview with the consultant in charge—as early as possible and, at any rate, as soon as a reasonable discussion of the present situation and future developments is possible; and (2) the promise by the hospital of immediate readmission for any urgency, whether technical or domestic—the policy of intermittent readmission. As has been said, it is the experience of geriatric units that when the relatives realize that the hospital regards them as equal partners in a common enterprise and is prepared to help if matters become more difficult, then the relatives will pull their weight. Success in this effort is not only essential to the community but may also be of inestimable benefit to the old person, for, next to the death of a beloved spouse, probably the bitterest blow that life can deal to old people is the realization that

their children no longer want them. They then indeed do become outcasts from society—desolates as well as isolates.

Conclusion

It is important not to forget the assistance that has been given in the past by good neighbours—in 1946 it was estimated that they provided nearly 20% of the home nursing of old men and 30% of that of old women. The changes in housing arrangements and in employment tradition have led to the severance of many intangible human ties, and one may, in fact, say that the major problem of the present time is to promote the conditions in which these ties of human affection, whether as kinsmen or as neighbours, can continue to flourish and so support the evening of the lives of our older people.

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PROBLEMS OF AN AGEING POPULATION*

BY

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The problems of ageing of the population are widely recognized as being of fateful significance both in the highly developed countries, whose populations are held by many to be ageing too much and at a too rapid rate, and in the underdeveloped parts of the world, whose populations would probably benefit from reproducing less and growing more aged. But it is in the highly industrialized and relatively affluent parts of the world that medicine is being compelled to an increasing extent to direct its attention to problems that bear some relationship to the ageing process. Mental illness is one of these problems, for the chance of developing it increases with advancing age. This is clearly evident in the Table and the Figure, which show that there is a steep rise in the first admission rate to mental hospitals between ages 16 and 25 and thereafter a more steady increase in women, while the rates for men show a temporary decline in the middle years. However, after the age of 65 the curve shows a steep upward gradient for both sexes. The curves for total admissions to mental hospitals are very similar in shape. It is not generally appreciated that it is only in age groups beyond 65 years, even according to the Registrar-General's figures, that the organic psychoses of senescence (mainly recorded under the heading of senile psychosis) become

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