



Looking Back

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MODERN HORIZONS IN GERIATRICS

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The Oxford Dictionary states that "horizon" is a noun meaning the line at which earth and sky appear to meet. The same dictionary defines "geriatrics" as a branch of medical science dealing with old age and its diseases, but I hope to show that this latter definition is too restrictive in a community which is concerned as much with ability or its loss as with the diseases that are related to disability, and as much with the effect on the individual of the social and political sciences as with the effect of the medical spectrum. Many of our foundations are shifting so rapidly that it is becoming increasingly difficult to distinguish what is solid and earthy from what may turn out to be nothing more than blue shadow.



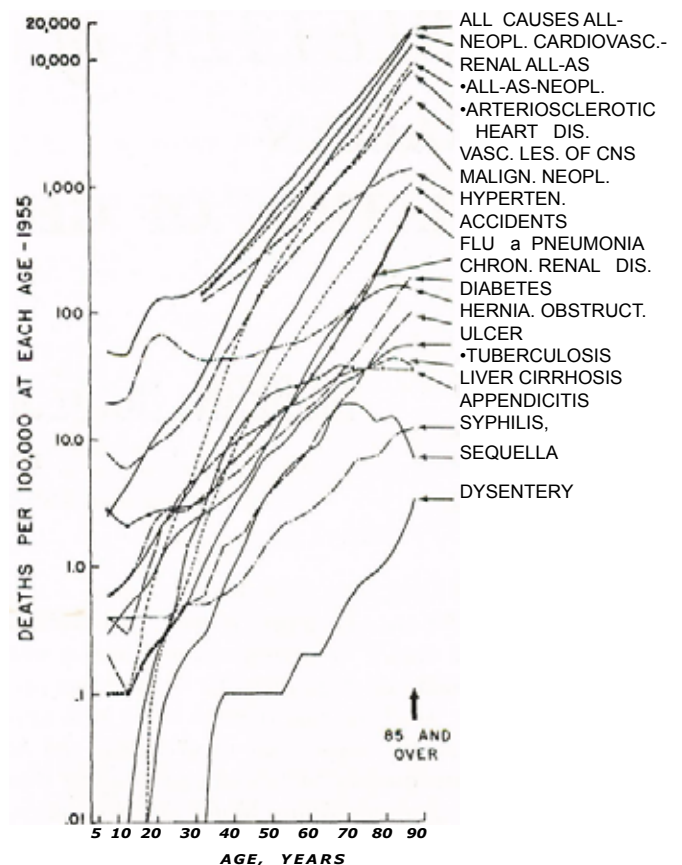
And yet there is a timelessness about much of our thinking. Look, for instance, at this quotation:

"Our youth loves luxury. They have bad manners, contempt for authority and disrespect for older people. Children nowadays are tyrants, they no longer rise when their elders enter the room, they contradict their parents, chatter before company, gobble their food and tyrannise their teachers."

These are not the words of a latter-day frump. They were spoken by Socrates in the 5th century B.C.

It is interesting to reflect on what the average expectation of life at birth was in those days, and how this average expectation has increased in recent times.

However, while the distribution of mortality in Roman times showed a youthful peak and the distribution in modern times shows a peak among much older people, the maximum longevity of man has scarcely altered. Some people approached 100 years of age in ancient days and a few do today, but there has been no significant extension of man's total life-span. The average expectation of people who have reached 60 years of age differs little from that of people who were sturdy enough to reach 60 years of age a century or more ago.





Australian life tables show that in 1920 the expectation of life at birth was 59.15 years for males and 63.31 years for females. By 1955 it was 67.14 for males and 72.75 for females. But the average expectation of those who had reached 60 was 15.08 for males in 1920 and 15.47 in 1955. Females did better, improving from 17.17 years in 1920 to 18.78 years in 1955. Those who attribute these increased expectations to better therapeutic services must believe that women have better treatment than men!

What has happened is that more and more people are surviving to live beyond the age of 60 years. Thus:

	Proportion surviving in	
	1890	1960
of those born 20 years before	81%	97%
of those born 60 years before	53%	81%
of those born 70 years before	No data	75%
		(Males 70)
		(Females 80)

This means that more people are surviving to ages when they become increasingly liable to the diseases which are common in old age.

Projections of the Australian population to the year 1976 have been made. They are calculated after allowing 100,000 migrants annually, and show:

Total population:	14,803,072	
65 and over:	1,199,311	(81% of total)
Males:	509,780	(42.5% of aged)
Females:	689,531	(57.5% of aged)

Applying these estimates to the population of N.S.W. one might guess that in 1976 our population of approximately 5,477,000 might have approximately 440,000 people aged 65 years and over. It has been estimated that the proportion of the aged will drop from the present 8.7% to approximately 8.1% in 1976, but the actual numbers will have risen by 92,000.

So then, that has one horizon pinned down.

A glance at the principal causes of death in N.S.W. may illuminate another area:

1962 Figures

Arteriosclerotic Disease	11,954
Malignant Neoplasms	5,257
Vascular Lesion of C.N.S.	4,939
Accidents	2,071
Pneumonia and Bronchitis	2,006
"Other violence"	649
Diabetes mellitus	518

	27,394

Total Deaths	36,861



Curves for all deaths and for 16 of the most common categories accepted in the U.S.A. as causes of death shows that the curve for all deaths becomes logarithmic after about 30 years, and that the probability of dying then doubles about every 8 years.

We note also what current research might achieve if present efforts are wholly successful. The life expectancy of adults might be increased from 1-3 years by the conquest of cancer, by about 7 years from the conquest of arteriosclerosis, and by about 10 years from the conquest of both.

However, while waiting for these days to dawn we are required to plan to meet the demands of those who are ageing now with the degenerative diseases of today. There is a rising burden of chronic disease with increasing age.

What types of service can society provide to minimise the disabilities of old people? I can do little more than enumerate them in this short talk. These services should be integrated, as loosely as is reasonable, because changes in one service might well have an effect on the demand for others.

There are several types of accommodation to be considered for the well aged; comfortable housing, specially adapted if need be, is an important factor in maintaining wellness.

Consider:

Own Home

Living with Family or Children

Low Rental Housing —Housing Commission
 —Charitable Organisations

Protected accommodation

Foster Homes.

There are two broad groups of domiciliary and supportive services which might be encouraged. One group concerns mainly the comfort and well-being of aged people who are living independently in the community. While these services are freely available to the sick and disabled, their prime focus is with social welfare rather than with doctors, hospitals and nurses etc.

These services include:

Social clubs

Home-aides and laundry service

Meals-on-wheels Day and night "sitters-in"

Escort Services; transport

Hairdressing

Library

Outings and entertainment

Reading

Shopping, collecting prescriptions

Provision and repair of radio or T.V. sets

Tape recordings for housebound

Handicraft instruction

Sheltered employment.

There should be some operational focus within local communities designed to ensure that existing services are accessible, and to meet local needs. Thought will have to be given to the appointment of executive welfare officers and to the administration and cost of the services.



In the field of professional care for the sick aged, individual practitioners in association with state and community agencies are developing services. These need to be expanded in some areas, given more emphasis towards the restoration of function in other areas. There may be need for co-ordination and integration of services in what our American friends like to call area-wide planning, by the provision of geriatric units, with in-patient and out-patient facilities, and the provision of such assistance in the home for the general practitioner as an adequate volume of district nursing, of equipment, of social workers, and of facilities for occupational therapy and physiotherapy. All require not only money, but trained staff. And thought will have to be given to this aspect. Recruitment and training need emphasis.

Not only will training programmes be required for professional personnel, but it may well be worthwhile exploring ways and means of modifying the community's attitudes and beliefs so that ageing can be achieved more comfortably than is often the case at present.

Individual counselling needs to be developed. Advice given in middle-age concerning diet, exercise and the value of periodic health examinations may be of some help to a good many people.

But the brightest star on the horizon is a new attitude that is becoming apparent in our thinking. We are no longer prepared to encourage needless dependence by keeping people in institutions when other arrangements may be satisfactory. We no longer forbid attempts by the disabled to get about, to walk down the road or even to shop and to use public transport. Risks may be worth taking, for to refuse them is to cause old age to be a regret, and one could then ask, with the editor of the J.A.M.A., "Why fix eyes that will not look, or repair feet which will not walk?" Natural inclinations must not be prematurely abandoned.

Retirement is thought by many to be a hazard. James 2:14 has for too long dominated our attitudes: "What doth it profit, my brethren, though a man say he hath faith, and have not works?" Why do we attach so much intrinsic value to work? Is it not worth examining Havighurst's suggestion that it should be possible to gain equal satisfactions from play and work? If the enjoyment of leisure could be ensured, then James would give way to an earlier writer in Proverbs 17:22: "A merry heart doeth good like a medicine: but a broken spirit drieth the bones."

Too many people enter retirement with a broken spirit. To continue to earn or to participate in flexible retirement programmes would be of some benefit. But these benefits would be immeasurably reinforced by the removal of these disabilities of ageing which are socially conditioned, such as loneliness and lack of status.

Finally, and perhaps most importantly, reference must be made to the need for research. In every field touched upon in the course of this brief summary there is need for inquiry. It might be satisfactory in some fields to apply the solutions suggested in other countries, but in the areas of economics and human ecology and in the organisation and administration of medical and welfare services we must seek out the requirements of people in our own community and apply to their needs remedies which are acceptable to our own way of thinking.

REFERENCE

I.Kohn, Robert F. (1963). J. Chron. Dis., 16, 5-21.