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The elderly in eleven countries

A sociomedical survey

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Foreword

A visitor to Europe today after an absence of 20 or 30 years would be struck by the marked increase in the number of elderly and aged people, particularly women, and if he were to return in the year 2000 he would be likely to see even greater numbers of the elderly and aged. In the year 2000, if present trends continue, he would observe the same phenomenon not only in the developed but also in the developing countries.

It was not long after the world, and Europe in particular, began to recover from the Second World War that achievements in health and social welfare began to be reflected in the demographic structure of the population. The fall in death rates, and also in birth rates following an initial rise, resulted in an increase in the relative and absolute numbers of the elderly.

Growing awareness of these demographic changes and their health and social consequences led the Member States of the WHO European Region to request the Organization to develop a programme on the health care of the elderly. However, during the initial stages of the programme it came to be realized that more detailed information on the elderly would be needed, since most of the statistical data grouped together all persons over a certain age without taking account of specific situations. It was known that multiple diseases resulting in long-term disability were major health problems among old people, but it was often difficult to distinguish them from the general health problems of aging. To this must be added the environmental, economic and social difficulties that together create a situation of dependence and dysfunction. It was also known that the elderly are not a homogeneous group, in that their health and social needs vary greatly.

To throw more light on these problems the WHO Regional Office for Europe initiated an international population-based study, on which this is the first report. It must be stressed that the findings reported here are preliminary and descriptive; much more information was generated

by the study than it was possible to include here. This book provides, however, a valuable first step towards a better understanding of the health and social problems of old people during the last decades of this century.

I should particularly like to thank the governments of, and institutions in, the participating countries for their cooperation in this study.

Leo A. Kaprio
*WHO Regional Director
for Europe*

Preface

The population of the European Region is aging: between 1950 and 1970 the number of people aged 60 years or more increased by over 30%. If this trend continues it is expected that between 1980 and the year 2000 the number in this age group will rise by a further 35%. In the very old — those 80 years of age and over — the relative rate of growth is even more dramatic.

By itself an aging population does not mean a greater demand for health care. In general the need of old people for health care is no different from that of other age groups, at least in the immediate post-retirement period. There are, however, very important social and economic problems that may well have an effect on health.

To be able to formulate health and social policies and plan for services we must have adequate information on the elderly, particularly on their health and socioeconomic problems, but much of the information at present available on the overall situation of the elderly arbitrarily groups together all those over a particular age, usually those who have retired. Present evidence suggests that the use of the health and social services varies greatly with age, even within the elderly group. Aging causes changes in morbidity and disability. There may be different rates of aging in different countries, and people's health expectations may vary according to their cultural and educational background and may thus be reflected in the use of the health services. The rate of aging may also vary over time with changes in economic and other factors.

Preparations for this survey began with a meeting in Copenhagen in December 1976, at which the broad orientation of a baseline study to be used for this purpose was considered. Subsequently, a protocol was drawn up and used in recruiting investigators from countries intending to participate, and a questionnaire was prepared and tested in the field.

An initial meeting of the investigators was held in Kiev in November 1977. The study protocol and questionnaire were reviewed and suggestions made for revisions, which were carried out by a steering group convened in Copenhagen in February 1978. It was also recommended that pilot studies be undertaken, and these were conducted in Finland, Poland, the USSR and Yugoslavia. In September 1978 the investigators concerned attended a meeting in Copenhagen, at which they proposed modifications to

the protocol and questionnaire in the light of the experience gained in the pilot studies. The final versions of the study protocol and questionnaire were reviewed and adopted at a meeting in Cavtat, Yugoslavia in November 1978.

All the Member States of the European Region of WHO were invited to join the study and 11 accepted. The study was eventually carried out in 15 centres in 10 countries of the European Region, and also in Kuwait from the Eastern Mediterranean Region of WHO. The survey data and other information received from the individual participating centres revealed that some of them, for various reasons, had not always adhered to the agreed working protocol in all its detail. This was not a serious problem in terms of the analysis and presentation of reports from the individual centres, nor did it affect the relevance of the findings for each of the participating countries. It did, however, make comparison of the data difficult and placed certain restrictions on the processing and analysis of the total volume of data. It was therefore decided that the first report would concern itself only with the methods used and the general findings in respect of age trends, sex differences and the overall variation between the centres. A more refined analysis, focusing on lifestyles, satisfaction with life and various aspects of living conditions, will be presented in subsequent reports. This work is being coordinated by the Editorial Board in cooperation with the Regional Office, and care is being taken to select material not affected by methodological differences in data collection.

To acknowledge all those who helped in collecting and preparing the data for this book would take many pages. In some centres nearly 100 individuals were involved in one way or another. Full details of those who contributed in these surveys are included in the individual reports from the various centres. Thanks are due to the many interviewers who took part in these studies in different countries. We should particularly like to thank Dr R. Glyn Thomas who, as the officer responsible for the regional programme on health of the elderly at that time, contributed in no small measure to the successful development of the study.

Finally, special thanks are due to the old people themselves, without whose cooperation the survey could not have been carried out.

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Introduction

Because the relative and absolute numbers of the elderly are increasing in most countries of the world and the information at present available on them is limited, the surveys reported in this book were planned to provide data from a number of centres in the European Region. The surveys are a result of a resolution of the twenty-fifth session of the Regional Committee for Europe requesting the Regional Director to initiate and coordinate studies on the specific morbidity and mortality of the elderly, paying particular attention to the socioeconomic, cultural and environmental factors that may be associated with disease in this age group.

The definition of the elderly is different in different studies. The threshold of old age can be either 60 or 65 years (1), although according to the Report of the United Nations Secretary-General for 1980 (2), for the purposes of the General Assembly of the United Nations it is considered as 60 years of age and over. The term "aging" is in some ways more appropriate than "the elderly" or "the aged", as it suggests continuing development and change during the later stages of the lifespan rather than a static situation. For statistical and demographic studies certain categories of the aged, however arbitrary, are needed. Much of the present information on the elderly arbitrarily groups together all those over a particular age, usually the retiring age. However, the elderly, however defined, are far from being a homogeneous group, and the use of health services varies greatly, even within the highest age groups (3,4).

Health and Functional Ability

Health is one of the main objectives of social policy; in many industrialized societies health care expenditure has not only increased but has often grown faster than the gross national product. The social, demographic, and epidemiological changes that have occurred during recent decades have led to a situation at present in which about half of the entire health care budget may be allocated to the medical care of the elderly.

The care of the elderly has been a major problem for many years, a problem that has increased and, in most countries, will continue to increase for many years to come as more and more people enter the highest age

groups. The increase in the number of the elderly carries with it important social and economic implications. In the United Kingdom it has been estimated that the expenditure per head on health services among those aged 75 and over is almost six times that of those aged 16-64 (5). Obviously the use of services, and hence the expenditure on them, depend not only on the morbidity of the elderly but on economic and social factors as well.

Aging is associated with an increasing prevalence of many chronic diseases and disabilities. About two thirds of chronic diseases requiring treatment are found among people aged 65 and over, and about one third of persons aged 75 and over are chronically ill, various supportive measures being needed to help them cope with the activities of daily life. The number of diseases observed, however, depends very much on the thoroughness of the investigations.

The prevalence of physical handicap increases with age. For example, Harris (6) found that nearly two thirds of those with appreciable handicap (needing some support) and with severe handicap (needing considerable support) were over the age of 75 years. Nearly three quarters of the very severely handicapped were over the age of 75 years. Social factors and handicap are associated; Harris also found that, of those aged 65 and over whom he classified as disabled, 30% lived alone, as compared with 22% of the total population in that age group. Other studies have found that one third of persons aged 65 and over living in institutions were unmarried, as compared with one tenth of those living in private households (7).

Elderly patients differ from young patients in several ways and this has led to the establishment of geriatrics as a separate medical specialty in many countries. A striking feature of disease in older people is that it is often multiple. This may lead to problems not only in the actual diagnosis and treatment but also in the length of time required for the investigation and for therapy.

Vital statistics, including death registration and census information, have been available in many countries for more than a century. However, very little work has been done on the health, social conditions, needs, and problems of the elderly, although mention should be made of the pioneering studies of Charles Booth in the last century (8) and of J.H. Sheldon (9).

What is needed is a baseline for comparison with future studies (to establish a cohort effect, if any). Demographic projections in several countries suggest that the age structure of the elderly will change appreciably and that an increasing proportion will consist of the very old. Further information is needed on the implications for the health services of such demographic changes. Previous studies in this field have rarely been population-based and the samples surveyed have often not been representative. Few international comparative studies have considered medical and social factors together.

Despite the high prevalence of chronic conditions, most elderly people feel themselves to be healthy (10). Often the very old evaluate their health as being as good as that of younger old persons. Health as subjectively perceived is nevertheless associated with impairment of movement and decline in both sensory function and general functional ability (10). Some persons

overestimate their state of health in relation to their functional ability (health optimists) and others underestimate it (health pessimists). The subjective estimation of health is regarded in gerontological research as a valuable tool. It influences, for example, satisfaction with life and the demand for services (11-13).

Less than 10% of people aged 65 years and over live in institutions. Of non-institutionalized old persons, less than 5% are bedfast, some 5-15% are housebound, and some 5-20% are ambulatory only with difficulty (14). Various indexes of independence in the activities of daily living have been developed (10,15,16). There is great variation in the rate of decline of physical activity both between individuals of the same age (intra-cohort differences) and between groups at different times (inter-cohort differences). Complex functions are most sensitive to aging processes, whereas simple basic functions are maintained relatively well even into very old age (15).

Impairment of mobility is one of the most important factors inhibiting independent living among the elderly. Mobility is clearly restricted in about 15% of persons aged 65-74 years, whereas the corresponding figure for people aged 75 and over is about 30% (17). No major differences were observed in the mobility of elderly persons in six western countries; this suggests that the physical capacity of the aged may be independent of culture (14). This suggestion is based on few cross-national studies; additional research is needed to confirm or refute it. It may be assumed that health and functional ability during life are dependent both on way of life and on socioeconomic conditions, but selective mortality and other selective factors may well diminish the differences between the very old. This was one reason for including younger old persons in this study.

Way of Life

The way of life of old people has undergone rapid change during the processes of urbanization and industrialization that have changed the physical living conditions of advanced societies. Very little, however, is known about the difficulties they experience in adapting themselves to the modern way of life. Whereas the physical living conditions of old people have greatly improved, particularly during the last 30 years, loneliness, dissatisfaction, dependence, loss of meaningful roles, depression, and other problems are often mentioned as characteristic of them.

A number of social gerontology theories try to explain the social processes of aging (18). The basic principles of the main theories are partly contradictory, which indicates the insufficiency of present knowledge on aging. The concept of way of life in sociological research (19) takes into account living conditions at different times, social functions (particularly social networks and relations), and the priorities of various functions. The way of life develops gradually as a process based on social and environmental change.

Closely related concepts — lifestyle, quality of life, and standard of living — are used to analyse specific aspects of the way of life. In medical research studies are most often limited to the areas considered most relevant

to health. Thus, smoking, nutrition, physical activity, and the use of alcohol have been investigated among the elderly (20–23). In social gerontology investigations have been carried out on social contacts, social participation, hobbies, and life satisfaction (13,24,25). It appears that a meaningful social role, a positive self-image, and a world view are important in predicting the future of the elderly. By combining knowledge about the biological, psychological, social, and medical aspects of aging it is possible to increase understanding of the problems of the elderly and to develop adequate services to meet their need for help and prevent premature dependence and unnecessary institutionalization (26). Very little information exists about the way of life of the elderly in different countries and few cross-national studies have as yet been published on this question.

Services

The forms of care for the elderly depend on the sociocultural and economic systems and situations of each country. In the industrialized countries organized official services for the elderly have become increasingly more common than help from relatives, but there still exist countries with deep-rooted family systems in which the responsibility for the care of the elderly still remains with the family (3,27).

The growing proportion of old people and, in particular, the sharp rise in the number of the very old make information and social planning essential. Demographically, the situation of elderly people is dominated by the large number of old women who form the majority of the clients of the care organizations. Many such clients are widowed, chronically ill, housebound, and unable to cope with daily living. To ensure the best possible quality of life, elderly people need financial security and combined forms of care establishing a proper balance between open and closed care and providing flexibility in meeting individual needs. Current systems of delivering services to the aged have been criticized as being fragmented and disorganized (28,29). Clear criteria for the provision of services are often missing; the needs or resources of the elderly could serve as the basis for the services (30,31).

During the last ten years a number of studies on the social and health services of the elderly have been carried out. The research results are, however, scattered and it is difficult to form a total picture of the situation. Few international comparative studies have been carried out. The countries in which a systematically arranged social policy is traditional have been pioneers in the planning and implementation of studies on the need for and use of services among elderly people. In the care of the elderly the integration of health and welfare services is needed. In some countries all the services needed have been incorporated into one organizational system, and attempts towards the same end are being made in several others. In the present study the use of the health services and of certain welfare services is investigated. Together with an inventory of services in the study areas that it is proposed to prepare, it will make it possible to estimate the discrepancy between the need for and the supply of services for the elderly.

Terminology

Terminology, particularly in the sociomedical field, changes with time owing to the development of new concepts and scientific achievement. One important characteristic of current developments in the care of the elderly is a broadening of approach, involving many disciplines. The terminology used in the 1960s was slightly different from that which came to be used in the 1970s, and both differ somewhat from present terminology. Material published over the last 20 years or so has been quoted in its original form, using the terminology valid at the time. The reader should therefore not be unduly concerned about apparent inconsistencies in the terms used in this report.

Purpose of the Survey

The aim of this interdisciplinary survey was to produce standardized and comparable data from representative population samples on the health and functional ability of elderly people and their use of health and social services. It is recognized in the study that the use of health services depends not only on the level of health of the population but also on the social support available. Therefore an inquiry on the way of life and on social support was required.

In addition to providing the information needed to plan health services for the elderly in future years, the study can be used to generate hypotheses about levels of health, the process of aging, and the need for services in different geographical areas. It is hoped that they will provide a basis for research on action aimed at preventing premature disability and enhancing the health and wellbeing of the elderly.

The aim of this report is to provide details of the methodology of the study and to present preliminary descriptive data on the non-institutionalized elderly. In view of the descriptive nature of the report, no confidence intervals or statistical tests have been used. Separate reports are available, or are being prepared, from the individual centres. It is hoped that comparative studies and in-depth reports, using the material collected in these surveys, will be made available in the near future.

