Considering the Aged

A. L. CHAPMAN, M.D.

MANY institutions and many programs are feeling the pinch of greater and greater demands on their facilities by older people. At the Peter Bent Brigham Hospital in Boston, for example, 7 percent of the patients during 1913–18 were 61 years of age or older as compared with 20 percent for the 1938–43 period. At present, the ratio is well above 20 percent and may approach 30 percent. Unpublished records from the Massachusetts General Hospital in Boston, as another example, show that the average age for all medical admissions, excluding pediatrics, rose from 35 years in 1912 to 60 years in 1949.

In the visiting nurse programs, too, the caseload has become increasingly weighted with older and chronically ill persons. Some estimate that approximately 50 percent of the visiting nurses' time is spent with these patients.

In a rehabilitation clinic for the crippled and handicapped, my final example, the ratio of approximately 5 children to 1 adult a few years ago is now nearly reversed.

It is not surprising, therefore, that anyone engaged in public health work or private medical care finds himself a practicing gerontologist. The public health practitioner, more than ever, must be prepared and willing to accept the new responsibilities imposed on him by an aging population and to find new ways of working with other professions concerned with the same problem.

Dr. Chapman, an Assistant Surgeon General, is chief of the Division of Special Health Services, Public Health Service. *This article is based on a lecture given at the Summer Institute in Social Gerontology, held at the University of Connecticut in Storrs, August 28, 1958.*

The seeds of chronic illness are planted early in life, perhaps before birth, necessitating a continuum of services throughout life, from infancy on, and not abruptly at the onset of old age, when chronic illness is most prevalent. The multiplicity of services and organized community efforts required by patients with chronic illness makes the health of older people everybody's business. To provide effective community response to the increased importance of socioeconomic factors, the resources of many agencies and people need to be pooled. Of course, the demands of the chronically ill and aged are in competition with other insistent matters such as radiological health, air pollution control, accident prevention, and the traditional concerns of the community. Thus, consideration of the older person's needs must be balanced with the needs of all members of the community, regardless of age or status.

Control of Chronic Disease

Many public health officials prefer the term "control" to "prevention" when speaking of chronic disease, primarily because of the broader implications of control. Control of chronic disease has been described as the maximum application of existing knowledge and resources to reduce the impact of chronic disease on the individual, his family, and society.

This concept may be considered in the light of five levels of control proposed by Dr. Hugh R. Leavell and Dr. E. Gurney Clark: health promotion, specific protection (primary prevention), early recognition and prompt treatment (secondary prevention), limiting the extent of disability, and rehabilitation.

Obviously, a community program meeting all these needs is an idealistic goal, but a synthesis

of services at each level would produce a comprehensive program. As the center core of health and medical services for the older person develops, other agencies and personnel will be found contiguous to the core and influencing the health of the individual. Basic planning for health must include, therefore, cooperative action in housing, employment, recreation, and education.

What are the activities which might be performed on each of the five levels of chronic disease control?

Health Promotion

Health promotion encompasses all educational activities which teach people how to maintain and improve their health. For the health agency, this means providing information on diet, rest, recreation, sound personal habits, and the availability of community resources in times of health and illness.

In promoting health, of greatest importance is the need to eliminate prejudices that are all too prevalent among the families of older people, professional groups, and among older people themselves.

Specific Protection

Primary prevention is more commonly practiced in communicable disease, the occurrence of which may be averted through immunization or isolation, than in chronic disease, knowledge about which is insufficient to permit specific protection except in certain instances. Among these instances, one may point out the possibility of industry's preventing occupational cancer through the removal of carcinogenic substances in the environment and the possibility of preventing accidents, particularly in the older age group and in the home, by a variety of measures. If the relationship is firmly established between smoking and lung cancer and between fats and cholesterol in the etiology of atherosclerosis, then specific protection may be equally applicable here.

Secondary Prevention

Of utmost importance at present for the control of chronic disease is the detection of a disease in an early stage and prompt treatment to check its progress and to retard any ensuing disability.

Widespread secondary prevention of chronic disease has been witnessed in the past few years. Single and multiple mass screening programs and periodic health appraisals in the offices of physicians, in hospitals, and in industrial clinics have given promise of providing an important wedge in the control of chronic disease.

Based on the concept of the well child conference, which places children under medical supervision while they are still well, a new development in geriatrics is taking hold. This is the well oldsters conference to which apparently well older people may come for counseling, guidance, health appraisal, and referral to medical care services when necessary.

Limiting Disability

When a disease is clinically advanced or is incurable, other measures must be taken. The services for the aged or chronically ill which attempt to limit the extent of disability cover a broad spectrum of medical and nursing care. To meet the ideal of comprehensive care, the patient would be cared for in his home, in outpatient clinics, physicians' offices, general and special hospitals, nursing homes, and homes for the aged.

Rehabilitation

Services to restore an individual's physical, mental, social, and vocational state as completely as possible may be found in such diverse places as a nursing home, hospital, or large metropolitan rehabilitation center. Many kinds of services are offered, such as physical and occupational therapy, medical and nursing care, and the adjuncts of vocational guidance and counseling, social service, and sheltered or homebound work opportunities. Thus, at the level of rehabilitation, perhaps more than at any of the other four levels, the active participation of a multidiscipline team is essential to effective operation.

Deterrents to Programing

For the most part, the deterrents to a community health program for the chronically ill and aged are socioeconomic, and may appear among any of the following, which are of con-

cern to public health workers: (*a*) the personality of the older person, (*b*) his social and cultural background, (*c*) his economic status and ability to pay for services, (*d*) the attitude and orientation of the community, its leaders, and professional groups, and (*e*) the availability of community resources and services.

As people age, they become less and less like other people of the same age. They become individualists, and treating them as a homogeneous group becomes more and more difficult. Any health program that depends on a mass approach must take account of this fact. Older people have participated only to a limited extent in community X-ray surveys, multiple screening clinics, and mass immunization programs for poliomyelitis. Even when specialized geriatric programs have been established in hospital outpatient departments, the response has not been enthusiastic. It is as if the older person views these events as further attempts to isolate him, and the belief outweighs the advantages he may see in preferred treatment.

Social isolation of many aging people is a factor closely related to their failure to participate in community programs. The loss of job, spouse, family, and friends, and the gradual restriction of social activities may very well mean infrequent and brief contact with those who remain.

Education aimed at social or cultural groups in schools, industry, service organizations, or elsewhere will not reach many of these people. In fact, the educational media of radio, television, newspapers, and other printed materials may also fail in their goals because of this isolation. How can health services and programs be "sold" to the individual whose main contact with the outside world is a monthly check from the Social Security Administration, an infrequent visit from a welfare worker, or an occasional, superficial exchange of conversation with local trades people?

Chronic illness and its restrictions upon activity add to social attrition and accentuate, furthermore, the defeatist attitude of the older person and of society as a whole. The attitude of "why bother" when one is old, sick, and alone can lead to a failure of, or lack of interest in, rehabilitation activities for older people. Since the goals of rehabilitation for this group are, for the most part, no more than self-care or activities of daily life, not full employment, the professional worker and older person may become disinterested and apathetic. Rehabilitation is hard work and the measurement of clear-cut results is often difficult.

Of importance, too, is the attitude of aging people toward preventive medicine. They have been reluctant to participate, as mentioned before, in many different kinds of preventive programs. Surely, their attitude is more than simply not wanting to bother; the feeling may spring from deep rooted fears of not wanting to borrow trouble: "What I don't know won't hurt me." Then, too, the past and present are more important to the older person than the future, so that health measures taken today for the future prevention of disease and disability have little meaning to him.

Prepaid health insurance plans for this age group may be the best solution, but the task of "selling" such plans is an additional burden.

Care for the Older Person

The emphasis on youth and work in America undoubtedly has had a bearing not only on the pattern with which health services have developed but, as has been indicated, on the use of these services as well. In addition, industrialization, a mobile population, and the dwindling size of families and of living accommodations have created a demand for new services and programs for older people and yet at the same time have proved a deterrent to these services.

To illustrate the increasing demands for specialized services, let us consider the phenomenal growth of nursing homes in the past decade or so. At present, an estimated 300,000 aged persons are being cared for in some 25,000 nursing homes and related facilities, where, for the chronically ill, nursing care is the predominant need. The demand for such institutional care is still growing, but many older people still remain in general and special hospitals, particularly mental institutions; adequate nursing homes cannot be found for them.

It is obviously a problem with both qualitative and quantitative aspects. Qualitative control of nursing homes by licensure, inspection, and establishing standards has become predominantly a public health function. A tre-

mendous task remains to be done to provide an adequate number of good nursing homes, well equipped and fully staffed with competent help. Licensure is not enough. Steps must also be taken to recruit and train nursing home personnel and to educate the community with regard to these needs.

The solution of the nursing home problem will not end the struggle of caring for the chronically ill and aged person. As a matter of fact, some 80 percent of the more than 2 million aged who were disabled for 3 months or more last year were cared for in their own homes. For those older persons living with spouse or relatives or with adequate resources for supervision, care in the home may not have been too difficult. But for the large numbers of older men and women living alone in inadequate quarters and with no one to assist them, home care is impractical however desirable. Organized home care programs are finding that these individuals need more than the medical and nursing care that they get in the home; they need homemaker or housekeeping services as well.

Homemaker services originated as a stopgap measure to prevent the dissolution of a family by providing a substitute parent during periods of disaster and stress. Like so many other programs, it was thus directed primarily toward children and their care.

In the past few years, however, there is increased awareness that other persons, primarily the chronically ill and older person, need these services. Some homemaker programs are attempting to meet these needs, but demand exceeds present capacities.

The goal of caring for the older person in his own home is obviously not easily achieved. The growth of home care and homemaker services is an essential part of the comprehensive program of care, but other means must be sought, such as foster home placement or the development of new facilities for graduated and selective care tailored to the immediate needs of each patient.

The Public Health Service is currently studying such a facility at the Manchester Memorial Hospital in Connecticut, which is providing care: (*a*) for the critically ill patient, (*b*) for those not dangerously ill, and (*c*) for those who are ambulatory and capable of self-care. An adjoining unit provides long-term care, and home care has also begun.

Another step toward better care of the homebound patient, in this instance the stroke victim, has recently been taken by the Public Health Service. Many patients who have suffered strokes may either never be admitted to a hospital for care or, if they are, are discharged to a nursing home. Because members of the family are ignorant of how to prevent deformity and disability, they and professional personnel alike have watched helplessly as many victims of stroke have become permanently crippled and bedridden. Early ambulation of the stroke victim and active and passive exercises are means by which disability may be limited, and members of the family may aid the patient in these respects, thus saving the time of professional workers.

To aid in the limitation of disability, the Chronic Disease Program of the Public Health Service has prepared a booklet entitled "Strike Back at Stroke." Based on the family physician's prescription, it is an illustrated instruction manual for the stroke victim's family to assist them in his care.

Thus we find new programs developing as the result of socioeconomic changes, programs that are based on the premise that the most logical and acceptable place for the care of the older person is in his own home. In addition to those described above, there are other community programs such as "Meals on Wheels" (which has aptly been called the "Bicycle Built for Stew"), which serves hot, nutritious meals in the homes of older persons incapable of preparing their own meals.

Recent studies in urban communities have shown that homebound older patients would prefer assistance with simpler tasks, such as marketing and personal errands, or companionship, to meals served at home. The need for some degree of independence is still felt by older persons, regardless of the extent of their handicap or capabilities. The need for friendly visiting programs or housekeeping services therefore becomes more apparent.

Many activities, we see, not usually considered a part of public health are relevant to the health of older people and extend beyond the

clinical and pathological aspects of aging. Public health workers who would help these people conserve their health cannot, therefore, ignore the older person's requirements in food, clothing, and shelter. Nor can public health workers ignore the interdependence of health and leisure, employment, and social relationships. It follows, therefore, that to obtain optimum adult hygiene, the disciplines of medicine, public health, and the social sciences must be called on for help.

Training and Education

The fact that public health workers have, without any directed change of policy, found themselves working with older people entails training the health specialist so that he may have the necessary knowledge and skill to perform his new responsibilities capably.

Training in chronic disease and aging is needed at two levels: formal, long-term courses for professional workers prior to their entrance into public health, and short-term refresher or "re-tread" courses for those already in the field.

A recent study of the curriculum of schools of public health revealed that a surprising amount of time (indeed, a continually increasing amount of time) was spent in lectures, seminars, field visits, and student assignments on chronic disease and aging. Professional training is exposing public health workers to basic concepts and problems relating to the chronically ill and aged person.

Short-term training is gaining momentum, also. Large numbers of professional, semiprofessional, and lay persons have availed themselves of refresher courses, seminars, institutes, inservice training courses, and the like. These activities have brought to the participants new skills and knowledge, but more important they have stimulated interest and provided an impetus to community programing.

Need for Research

In describing the impact of aging on health programs, I have hopefully indicated, perhaps indirectly, where gaps exist. The social scientist may help fill in these gaps through research. Health workers, in order to develop sounder programs for the older person, need more information on (*a*) the attitudes of the community, professional workers, and the elderly on aging and programs for aging persons, (*b*) the reasons behind the use or nonuse of community health facilities, (*c*) the relationship of health and illness to work, leisure time activities, and attitudes toward others, (*d*) the important factors that motivate older persons to seek rehabilitation, and (*e*) the barriers and incentives to good community planning.

Changes have taken place that necessitate a fresh approach to the solution of the ever-increasing problem of an aging population. We in public health feel that this is one of the most important tasks confronting us today. Experimentation with new techniques and the application of present knowledge are not enough. Our ultimate goal cannot be reached without the strength and support of further research. And that goal will be reached when, through comprehensive community planning, we succeed in enriching the later years as we have extended them.