

The Older Population and the Aged Patient

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Modern medical practice requires that the physician and other members of the health team have full appreciation of the impact of disease and disability upon identifiable groups of patients and recognize how nonmedical factors affect treatment and prognosis. It is important for the physician to have some idea of the patient's socioeconomic status and the actual and potential number of patients with not only a common diagnosis, but also similarities in their living conditions. With such knowledge, the physician can be much more realistic and efficient in his therapeutic efforts.

Persons 65 years of age and over are commonly referred to as *the older population*. Brotman (1968) recently identified the special characteristics of those 75 years of age and over, referring to these people as "the aged." This subdividing of the older population is of considerable value, as the important health and socioeconomic facts common to a specific group can be lost in the mass of the older population.

The Older Population

In the United States there are 18,500,000 men and women age 65 and over; hence, one in every 11 persons in the United States is age 65 or over. Since 1900, the percentage of the United States' population age 65 and over has more than doubled (from 4.1% in 1900 to 9.4% in 1965), while the actual number of aged persons has increased sixfold (from 3,000,000 to more than 18,000,000). There

has also been a clear reversal in life expectancy for men and women. Women are now outliving men; in fact, there are about 129 older women per 100 older men. Life expectancy for women is still increasing faster than for men. During the next 20 years, although it is unlikely that the percentage of older people will increase, the actual number will go up to 25,000,000. Assuming that the life expectancy trends continue, by the year 2000 the ratio of women to men will be 148 women to 100 men.

Living Arrangements

The majority of elderly people are living in the community. Only one in 25 lives in an institution such as a rest home, nursing home, or medical facility. There are, however, some striking differences between the way the men and the women live. Two-thirds of the men live with their spouses, but only one-third of the women have husbands. Moreover, only one-sixth of the men live alone or with non-relatives, while one-third of the women live alone or with non-relatives. Less than three-quarters of a million elderly people require some type of institutional care. Consequently, greater emphasis must be given to making certain that the living arrangements for the elderly within the community are conducive to the maintenance of health.

Surveys of older people indicate that they want to live apart from their children but close to at least one of them (Shanas et al., 1968). Consequently, housing units for the

elderly should be conveniently placed so that the old person can have controlled intimacy in terms of frequency and distance. The units should be located so that it is not only possible but relatively easy for old people to see their families often and call upon them for help if and when needed. Unfortunately, a small percentage of older people, probably around 4%, have no human contact for as long as a week. This small minority of aged individuals is truly isolated, and although such individuals are few, they are so scattered that they are difficult to find. When found, they are difficult to approach, usually rejecting any offer of assistance.

In a national study of older Americans, 59% of those living alone had been visited by an immediate neighbor the previous day, 46% by a friend, and 60% by relatives, including children.

Marital Status and Life Expectancy

As indicated above, most older men are married, whereas most older women are widows. There are almost four times as many widows as widowers. It should be noted that about two-fifths of the older married men have wives under 65 years of age. Furthermore, there are at least 35,000 marriages a year in which the groom, the bride, or both are 65 years of age or over. The number of marriages among elderly people has been steadily increasing.

The difference in married and unmarried status for older patients is of significance to the physician, for it has been noted that the hospital admission rates and stays of the unmarried exceed those of the married (Spiegelman, 1963).

There are about 5,000,000 couples with one partner over the age of 65. In this group 350,000 couples, or 7%, have annual incomes of \$10,000 or more. Nine hundred and forty thousand couples, that is, 18%, have incomes

between \$5,000 and \$10,000. The remainder of such couples, that is, 75%, have an annual income of under \$5,000; 52% are under \$3,000; and 7% are under \$1,000.

Unfortunately, the income distribution of persons age 65 and over who are living alone indicates that the majority are living in poverty. Eighty-nine percent have an annual income of less than \$3,000, and 62% are under \$1,500. It is evident that men 65 years of age or older not only are likely to have more money than surviving women but are much more likely to have a spouse. Although a man is less likely to live as long as a woman, the years he spends as an older citizen appear to be better ones than the many years spent in old age by a woman.

Work and Retirement

The number of men working after age 65 has decreased steadily since 1900. At that time, a man over 65 had two out of three chances of being employed. By 1965, only 25% of males, once they had passed age 65, were in the labor force.

Life Expectancy

Life expectancy is a computed projection rather than an observed or estimated phenomenon. The projection is based upon the assumption that the death rate experienced in a single year or the average of experience in a few years will remain completely unchanged in the future. Obviously, any event that influences future death rates, whether it be natural or man-made, automatically affects the accuracy implied in the prognosis of the computed life expectancy. Since the computed life expectancy cannot foresee negative events, it also cannot include positive changes. No assumed positive changes are included, e.g., changes in medical knowledge and care,

sanitation and nutrition; reduced mortality in traffic accidents and wars.

Human longevity is influenced by a complex of interacting factors including genetic makeup, environmental and nutritional factors, and psychologic, social, and economic influences.

Longevity in the United States has changed but little in recent years. The average length of life in 1965 was the same as in 1961. This plateau was the result of an unusually high prevalence of acute respiratory disease which caused a slight setback for two years.

In 1965, the expectation of life at birth for white females was 74.7 years, an increase of only one year since 1956. Among white males the corresponding figures were 67.3 years in 1956 and 67.6 years in 1965, a gain of just .3 of a year. These changes continue to increase the difference in longevity between the sexes. In 1965, the expectation of life at birth among white females exceeded that for white males by 7.1 years as compared with 6.4 years in 1956 and only 2.9 years at the century's turn.

Many more people are reaching old age, but once there, they are not living much longer.

In 1968 there were 7,300,000 men and women age 75 and over in the United States. The aged population is actually growing faster than the older population. Today, at age 75, life expectancy averages about nine years. Brotman estimates that if we eliminated malignant neoplasms as the cause of death from those persons now age 75, life expectancy would go up an average of eight months. If we eliminated deaths from heart disease, we would add three years and ten months. If we eliminated all types of deaths caused basically by cardiovascular-renal disease, we would add eight years and eight months to the life expectancy for the 75-year-olds.

As to the health of these individuals, there are some differences.

Those 75 and over are restricted in their activities because of illness about 12 days more per year than are those age 65 to 74; that is, the aged person is in bed at least eight days more per year, and in general, activity is limited as the result of chronic conditions. Of those 75 and over, 23.7% are unable to carry on major activity as opposed to 9.7% of those between 65 and 74 years of age. Interestingly, the average length of stay of those entering short-stay hospitals is essentially no different for those 75 and over and those between 65 and 74. Of all older persons, 4.4% are living in institutions. The majority of the institutionalized represent the aged persons; 8.1% of those 75 and over are living in institutions as opposed to 2% of those 65 to 74.

The marital status of the aged group reflects the social tradition for men to marry younger women. Twice as many aged men as women are married, and only one-third of them have wives 75 and over. About half have wives between 65 and 74 years of age, and one-fifth have wives under 65 years of age.

Of men 75 years of age or older, 33.9% are living with their wives. In contrast, of women 75 years of age and older, only 17.8% are living with their husbands. Of these women who are 75 years or older, 3% have husbands under 65 years of age; roughly 20% have younger husbands between the ages of 65 and 74, and the remainder have husbands their own ages or older. Each year approximately 2,000 women age 75 or older marry, and 6,000 men 75 years or older go to the altar. Both of these groups are usually moving out of widowhood. Of these 8,000 marriages, over 4,000 involve partners under age 75.

Physical and Mental Health

Fifty-two percent of all Americans over 65 say their health is good. Thirty percent describe their

health as fair, and only 18% say their health is poor.

About one-third of all old people over 65 living outside of institutions see a doctor during a four-week period. This means that in any given month some 6,000,000 people over 65 see a doctor, most often in his office or at a clinic; less often in their own homes. In contrast to younger patients, the majority of old people do not seek medical help for acute illnesses; rather, they seek help for chronic conditions. However, the elderly person also experiences acute illness, and although acute serious disease is frightening at any age, it is more threatening to older people. This is not because they fear death but because they dread disability, increased pain, and the possibility of increasing their helplessness and dependence on others.

As of mid-1963, about 292,000 persons 65 years of age and over with mental disorders were residents in long-term health facilities such as nursing homes for the aged, geriatric hospitals, Veterans Administration facilities, and private mental hospitals (Kramer, Taube and Starr, 1968). Fifty-one percent of these patients are in state and county mental hospitals; 43% are in nursing homes and similar types of facilities.

The close relationship between physical and psychological status in old age is particularly relevant, as chronic illnesses are prevalent among the aged and the incidence advances steadily with age. In young adulthood, that is, up to 45 years of age, 45.3% of persons have one or more chronic conditions. Fortunately these conditions produce limitations of activity in only 7.4%. However, according to a report published by the U. S. Public Health Service (1962), between the ages of 45 and 64, chronic conditions are present in 61.3% and limitations of activity in 18.3%. From 65 and over chronic disorders advance to 78.7% and disability to 45.1%. In a re-

cent survey of the elderly in the United States, 2.3% of the aged are bedfast, and 6.1% are confined to their rooms or living quarters. Of the remaining, 86.2% can go outdoors without difficulty, while 5.4% must exert considerable effort in order to venture forth. Obviously such individuals have difficulty maintaining their social activities, lose intellectual stimulation, and lack opportunities for learning. The institutionalized aged persons are particularly afflicted by the coexistence of physical and mental disability. One study indicates that this occurs approximately 80% of the time (Kahn et al., 1960).

Chronic Brain Syndrome

In recent years the proportion of older persons in mental hospitals has increased steadily. On any given day at least one out of every three beds in a public mental hospital is occupied by a person 65 years of age or older. Approximately one-third to one-half of the persons in the 65 or older age group in public mental hospitals were admitted as younger patients. However, the majority were admitted at age 65 or older. Eighty-three percent of first admission older patients are diagnosed as having senile brain disease and/or arteriosclerotic brain damage. The reliability of these clinical diagnoses has been studied for a number of years. The coexistence of senile brain disease and arteriosclerotic brain disease is not mutually exclusive. On the basis of autopsy material, it appears that 45% of elderly patients with organic brain disease are primarily ill because of cerebral arteriosclerosis. Thirty-five percent are suffering primarily from senile brain changes, and 20% show evidence of both pathological processes (Corsellis, 1962).

At the present time no etiology or treatment has been established for senile dementia. The possibility that senile dementia is related

to vascular insufficiency or disturbed blood flow through the brain has repeatedly been considered. Recently, anticoagulant therapy has been used successfully in patients with recurrent stroke and transient ischemic attacks. As a result, the concept has arisen that anticoagulant therapy might prove to be equally effective in the treatment of so-called senile dementia. In one recent report, the value of anticoagulant therapy was seen as encouraging (Walsh, 1968). However, it was recognized that the lowering of prothrombin in the blood can be very dangerous. Patients on this therapy, therefore, require careful monitoring, and in case of hemorrhages the antidote, vitamin K₁, must be readily available. This study used both warfarin sodium and dicumarol. The rationale of this approach is that it breaks up the sludge in the blood. Consequently, it has been speculated that antimalarial drugs may prove to be of similar usefulness.

Numerous attempts have been made to correct the learning and memory defects associated with organic brain disease. Investigations are continuing, and although results to date must be summarized as discouraging, considerable scientific information is accumulating that should result in effective therapeutic measures for at least those individuals in the early stages of disease process. In recent years ribonucleic acid (RNA) has been given orally and intravenously in the hope of restoring intellectual skills. Related substances such as uridine, as well as agents that are believed to stimulate RNA production, have been tried, but results have been negative or doubtful (Solyom, Kral and Enesco, 1968).

Psychoneurotic Reactions

The impression is often conveyed that psychoneurotic reactions in adults are chronic disorders that are sometimes fortuitously alleviated but usually require psy-

chotherapeutic intervention. Longitudinal studies suggest that there are older individuals who, after a period of time, develop psychoneurotic reactions in response to an unfavorable environment. Furthermore, recovery is quite possible if the individual is removed from the stressful life situation or is provided the means of restoring self-esteem. Two psychoneurotic reactions, depression and hypochondriasis, are frequently found in elderly persons. The possibility of a transient psychoneurotic reaction appears to be especially true of hypochondriasis and mild-to-moderate depressions. Careful evaluations conducted over more than ten years strongly support the view that the signs and symptoms of a psychoneurosis are unconsciously selected by the person so that he can maintain his self-esteem in a particular situation. If the sign or symptom is not an adequate defense in that particular situation, he will abandon that defense mechanism for one that is appropriate to the particular circumstances in which he is living. Hence, some psychoneurotic signs and symptoms "come and go" over a period of time. The exacerbations and remissions are largely determined by an identifiable constellation of socioeconomic conditions. Therefore, in some individuals the hypochondriacal pattern dominates, while in others the depressive attitude is the major factor. In general, the hypochondriacal elderly person is more likely to be a female of low socioeconomic status with little change in her work role, relatively younger and less socially active, with patterns of activities suggesting that they are not conducive to a good adjustment (Maddox, 1964). More specifically, the person is forced into a situation hopefully temporary where criticism is the rule and appreciation and work satisfaction are absent. This is compounded by the restricted social activity, so that rewards are few and far between.

It should be mentioned that, in contrast, there are elderly people who utilize a neurotic mechanism of denial; that is, they fail to realistically deal with important physical diseases. This type of person, a persistent optimist, should not automatically be seen as a person with courage, for the courageous person does have a realistic appraisal of the situation. The type of older person who is likely to utilize denial is a male of fairly high economic status who is not burdened with financial responsibility and a demanding work role yet has many and suitable opportunities for social activity (Busse, 1967).

Summary and Conclusions

1. Life expectancy is increasing faster for women than for men. The problem of the increasing number of widows is becoming a very serious one for medicine and society, making it necessary to find avenues of social participation which will be rewarding to elderly widows as well as other elderly people.
2. The vast majority of elderly people are living in the community. Only one in 25 is institutionalized. Consequently, greater emphasis must be given to providing adequate living arrangements that are conducive to the physical and mental health of the elderly.
3. The aged are currently being defined as men and women age 75 and over. Obviously the aged are the most disabled of the older population and require the greatest amount of medical attention. It is possible that these aged will require medical facilities of a transitional type which will permit them to move freely from full hospitalization to the community.
4. The older people in the United States do consume a large amount of medical practice time. In any four-week period one-third of the entire older population are seen by a physician.

5. Chronic brain syndrome remains a serious psychiatric problem among the elderly. Although there are many promising leads at the present time, neither the etiology nor the treatment has been established.

6. Psychoneurotic reactions in the elderly frequently occur in response to a stressful life situation and can be relieved by environmental manipulation rather than strictly by patient-directed psychotherapeutic techniques.

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