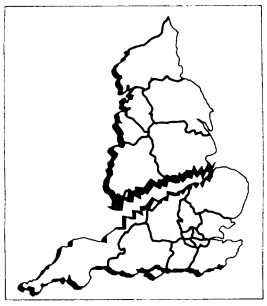

Challenge of aging

J Grimley Evans

Our idea of what constitutes effectiveness and efficiency in the health and social services depends on whether we are customers or purveyors. In an obsession with cost accounting and the ethically questionable issue of how many quality adjusted life years (QALYs) can be bought for each taxpayer's pound,[1] the government has been offering an exclusively purveyor's agenda for assessing health and community care. It is therefore refreshing to find that *The Health of the Nation*[2] is mostly concerned with customer interests—health rather than health expenditure and health outcomes rather than service processes.

Curiously, however, given the realities of health care in our aging population, older people are conspicuously absent from most of its pages. Premature death is taken to be death before the age of 65, a definition recalling times when individuals were valued only as exploitable labour. This now seems anachronistic, if only because expectation of life at birth is 73 years for men and 78 for women.[2] It may also be less than astute politically given that people aged over 65 comprise a fifth of the electorate and sooner or later will start voting with their heads.

More promisingly for older people, the document proposes the identification of key areas that can be defined in terms of avoidable ill health, and, even more importantly, ill health is to include disability. Rehabilitation services for people with a physical disability are offered as a possible key area. This too is promising provided that citizens aged over 65 are to count as people. Unhappily the document considers rehabilitation in the context of a publication from the Royal College of Physicians that did not include geriatric rehabilitation in its considerations. This could hardly be less timely. Experience from the US warns that under the contractual prepayment system of the reformed NHS, one way that managers will seek to trim hospital costs will be by withdrawing rehabilitation from older patients.[3] The brief paragraph dealing specifically with older people is ambiguous and possibly misconceived (box). Although the importance of a healthier old age is recognised, the document offers no programme for ensuring good health in elderly people and age associated disability is not suggested as a key area. (Age associated is a descriptive term with no implication that the disability is caused by intrinsic aging[4] or is an inevitable accompaniment of age).

Green paper strategy for elderly people

Between 1981 and 1989 the number of people aged 75-84 has risen by 16%, and those 85 and over by 39%.... Much of what this document says about prevention of heart disease, stroke and cancers is especially relevant to this growing number of elderly people. This is where the burden of avoidable ill-health finally falls. The government recognises, moreover, that success in reducing premature mortality will increase the number of elderly people and so, unless a healthier old age accompanies greater longevity, lead to a greater demand for services. That is why the emphasis must be as much on quality of life as on quantity of life.

Storing up ill health

Two messages seem to emerge from all this: the first, for the general public, is that the government's concern for the human sufferings caused by ill health in old age is primarily the associated nuisance created in a demand for services; the second, for the professions, is that preventive medicine is viewed simply as postponement of disease to an age when further avoidance becomes impossible and the cumulated backlog falls finally and, by implication, inevitably. It would be charitable to assume that these are false messages produced by maladroit drafting, but the second message offers a coherent epidemiological model that can be judged on its merits.

The incidence of most diseases increases with age, and in the case of some important preventable diseases such as cancers and stroke incidence shows a power-law relation to age[5,6]; with others such as proximal femoral fracture the relation is exponential. In general when incidence differs because of some extrinsic cause, and cohort effects are corrected for, the slope of the incidence curve remains the same but its intercept changes. The overall incidence of proximal femoral fracture measured in Oxford in 1966 and in Newcastle upon Tyne in 1975-6 differed by a factor of two but the exponential curves in the two studies were parallel.[7] There was no increased steepness in the Oxford data to suggest that fractures were being "stored up" into later ages. Mortality from stroke has been falling at similar proportional rates in both middle aged and older people.[8] The evidence therefore suggests that reducing extrinsic causes of disease will prevent some people from getting a disease rather than merely postponing the age at which they get it.

Disease may not be avoided, however, if preventive measures are not continued into later life. Healthy lifestyles are associated with increased longevity at the age of 70 as at younger ages,[9] though we do not yet know that the association is causal. There is increasing evidence of the predictive power of risk factors for vascular disease in old age.[10,11] The research necessary to assess the efficacy of risk factor modulation in later life must be carried out. But in the real world of medicine our ethical duty is to "manfully act upon the greater probability,"[12] and many gerontologists will feel that the burden of proof lies with those who want to treat elderly people differently from middle aged people in regard to prevention of disease. Certainly, such an attitude will be a more potent encouragement to government funded research than would the cheaper null hypothesis.

Health of elderly people as a key area

The Health of the Nation sets out clearly and reasonably what should be the criteria for identifying a key area; briefly it should be a major cause of concern and there should be scope for improvement for which targets can be set. Nearly 60% of disabled people in Britain are aged 65 and over,[13] and age associated disability is by any standard a major cause for concern. Differences in the prevalence of disability among definable social groups, in this country and elsewhere,

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together with evidence of the variation in incidence of disabling diseases such as stroke and proximal femoral fracture are clear indicators that improvements could be realistically looked and planned for.

The government's proposed approach to disability includes a focus on specific disabilities and impairments such as incontinence and pressure sores. For older people we now have a more global approach to measuring disability of all forms that could be used for target setting. This is the concept of active life expectancy,[14] in which life expectancy at any age is divided into average years left before death and average years left before disability intervenes. With routine data measures of active life expectancy often have to be approximated by measures of independent life expectancy—that is, years until the first use of informal or statutory help from others. Such measures are susceptible to bias from the availability of the services identified as defining dependency. Active life expectancy defined in terms of disability could be monitored in representative population groups by standardised and repeated surveys of abilities to perform specified tasks of daily living. A project of the Central Health Monitoring Unit in cooperation with the Office of Populations Censuses and Surveys is to be welcomed as providing a pilot for studies of this kind. Furthermore, it is not too fanciful to conceive of a time when the improved surveillance of elderly people recently introduced in primary care, together with computerised databases in primary care, could be used to monitor independent life expectancy in later life on a nationwide basis. This possibility is foreseen by the health services research committee of the Medical Research Council in expressing interest in the development of an effective system for use in the mandatory primary care surveillance of older people.

Active life expectancy could be increased by prevention or intervention, or both. A modest target would be that active life expectancy at age 65 should increase in its proportion of total life expectancy and by a specified annual percentage. A health authority could decide on the basis of local information how best to distribute its efforts between different possible activities in order to achieve this. For example, one authority might aim at reducing strokes by a programme of blood pressure control in later life; another might decide to improve its hip replacement programme.

BRENDA PRINCE

Unless increased longevity is accompanied by good health demands on services will grow

Separatist or integrationist strategy?

The case for recognising age associated disability as one of the government's key areas seems to be at least as cogent as that for some other topics suggested. Indeed, some will see its omission as positively anomalous. Assuming that the government has not cynically ignored a politically inactive section of the population, or failed to do its homework, what are the counterarguments?

One could invoke the longstanding dilemma of whether older people should be identified as a special group or merely as people who may have problems that the health and social services should be able to deal with whatever the age of the patient. This difference in philosophy has distinguished the "separatist" and the "integrationist" wings of geriatric medicine for nearly two decades, but the integrationists have never suggested that the needs of older people could be ignored. The essence of the integrationist philosophy has always been that services should be deployed according to need rather than age and must be as suitable for elderly people as for young. If the government were proposing an integrationist strategy, it should have made clear that elderly people were included in its focus on disability, rehabilitation, and preventable death. In fact elderly people have been implicitly excluded.

Whatever the reasons *The Health of the Nation* is surprisingly inadequate in its response to the challenge of our aging population. There is likely to be a more or less respectful clamour for the health problems of older people to be designated, in one form or other, as a key area in what is an important and exciting initiative. So debased has the coinage of public debate become that many will suspect that *The Health of the Nation* is merely a political document saying what the government thinks the public might like to hear in the run up to a general election. The government's willingness to enlarge its list of key areas to include age associated disability would be a significant demonstration of its genuineness in producing a consultative document.

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