Tracking demographic footprints

Two footprints in the demography of ageing can readily be identified that are associated with improving health and longevity, namely, the funding and redefining of retirement, the other associated with burdened ageing especially the impact of neurodegenerative disease-fuelled disability, dependency and demand for long-term care [1]. A report in this month’s journal highlights the importance of tracking the footprints of social trends as well as projecting the epidemiology of diseases associated with ageing [2].

With regard to the redefinition and funding of retirement in the United Kingdom, the state pension has diminished, and future proofed final salary pensions increasingly rare. The expanding retirement population and relative contraction of the working population is undermining the sustainability of the long established practice of paying for today’s pensions from current taxation. After many years of difficult debate government has made important pension policy commitments for the future [3]. These include the delay of retirement, partial retirement and greater pension contributions.

Furthermore, in July 2005, HM’s Treasury announced that a second Comprehensive Spending Review (CSR) would report in 2007, the purpose of the review being to identify what further investments and reforms are needed to equip the United Kingdom for the global challenges of the decade ahead. Preliminary publications from the Treasury have recognised that

‘demographic and socio-economic change, with rapid increases in the old age dependency ratio on the horizon and rising consumer expectations of public services’ [4]

And

‘a particularly important driver is the sharp projected increase in the number of “oldest old” (those aged 85 years and over). The size of this group is projected to increase by 38% between 2005 and 2017, compared to 17% between 1995 and 2005. The increase in the future elderly population can be predicted with sufficient certainty to mark it out as an important trend.’ [5]

Whilst the changing demographic footprints of burdened ageing have changed, the provision and funding for long-term care has historically been used by those suffering the effects of poverty, deprivation and neglect. In the United Kingdom, long-term care is now largely fashioned on a social care model. The paradox is that whilst the social care model has been successful in promoting more domestic care settings, the needs profile of older people receiving the services have become dominated by chronic disease-related disability.

The data from a record linkage study reports findings in this journal [2] of socio-demographic factors associated with a higher ‘risk’ of living in institutional care, namely people who have chosen (or perhaps been ‘chosen’) to live alone, particularly childless women. In 2005 the number of people living alone in Great Britain had more than doubled since 1971, from 3 to 7 million. An analysis of the age of people living alone from the general household survey [6] reveals the most striking changes are occurring between the ages of 25 and 64. For men in that age range there has been a near doubling of the incidence of living alone. The trend is less marked for women and from 65 onwards a modest reduction
of women living alone, probably reflects improving mortality in men.

Collectively, these findings make clear the continued importance of tracking and questioning the evolving interplay of social factors in relation to the propensity of people to need, or choose institutionalisation. It is unclear whether this increase of living alone in midlife indicates a transient phase or a new pattern that will follow through to later life and what implication this may have to the current findings on institutionalisation rates. Clearly, more information is required on the significance of trends in living arrangements.

The second issue that this report raises is whether we have an adequate contemporary definition of institutionalisation. In the United Kingdom for example, new housing options blur the distinction between housing and care. Few would argue that a retirement village was an institution, but differentiating Extracare facilities (a form of specialist housing with capacity to provide care) from a well designed modern care home, and determining whether Extracare facilities constitute an institution or housing is becoming difficult. This is important, not just for accurately tracking trends, but because the differences in commissioning cost, capability and regulation of these alternatives need to reflect the social diversity, physical dependency and level of vulnerability of the people that may choose or be offered these various settings. Perhaps institutions should be defined more by activity, admission rates, discharge and mortality. It then becomes clear that Care Homes with a typical annual mortality rate of around 50% [7] are addressing a very different population than a housing provision with an annual mortality rate of under 5% per annum.

Tracking and understanding ‘Demographic footprints’ requires sustained research, public awareness and debate and policy response perhaps similar to that provoked by the concept of ‘carbon footprints’ relating to environmental risk. What is clear is that the increasing diversity of living arrangements generally can reasonably be anticipated to be accompanied by continued changes in living arrangements in later life, as well as those consequent on financial capability, social, health and care profiles.

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References