Cameron Swift takes a fresh look at the scenarios concerning an ageing population

THE DEMOGRAPHIC TIME BOMB (THAT PROBABLY ISN'T!)

key points

- By 2050 there will be around 19 million people over-65 and eight million over 80 in the UK.
- The widely cherished notion of a good old age contrasts with the increasingly negative perception of an ageing population.
- Human longevity is identified biblically as a blessing, but like all good gifts it presents both opportunities and challenges.

A somewhat negative perception of population ageing in developed and developing societies has become a perennial cliché. In the UK in 2010, ten million people were over 65 years old. Current projections are for 15.5 million by 2040 and around 19 million by 2050. In 2010 there were three million people aged over 80, projected to reach nearly six million by 2030 and eight million by 2050. Alongside these crude population statistics, the Department of Health asserts that the average current cost of providing hospital and community health services for someone aged 85 years or more is around three times greater than for someone aged 65 to 74 years.[1]

The predominantly negative, explicit, public and indeed policy responses to this encompass incredulity, economic apocalypse, avoidance, and knee-jerk (rather than proactive) strategies. Similarly, private personal responses include fear (both older people themselves and their families and carers), resentment, stoicism, denial and strained relationships.

Yet there is still a widespread individual and societal incentive to care that is genuine (as well as perhaps born of enlightened self-interest). There are many wonderful examples of personal and organisational inter-generational harmony and provision that are fulfilling and inspirational – including the challenging area of dementia care. The growth in public awareness and research investment into the dementias is good news.

The concept of a good old age with mutually affectionate and strong interrelationships is still widely cherished. In stark contrast, however, are continuing recurring reports of abuse and neglect, and contemporary endeavours to promote planned assisted suicide on spurious grounds of absolute personal autonomy[2] or societal obligation.[3]

The phenomenon of population ageing is here to stay and the centrality of health and healthcare as cause and consequence requires that Christian medics confront the issues. The topic is wide and complex, but some core considerations are proposed:

Truth and scientific integrity, however counter-intuitive, must transcend prejudice (ageism). Public and professional prejudice perceives ageing as an inevitable, intractable process of declining health with diminishing returns for intervention – whether preventative, diagnostic and therapeutic, or prosthetic (supportive).[4] It is invoked often in policy[5] as an excuse for strategic non-investment in all three areas. But this is wrong. Here are some reasons:

Biological ageing (with associated disease propensity) is not primarily a consequence of self-destructive genetic pre-programming or 'wear and tear' but substantially driven by stochastic (random) molecular and cellular error, and is potentially amenable to intervention.[6] If a remaining life expectancy of less than 15 years (rather than crude chronological age) is used to define the dependent population of older people, there has been a downward trend in its size since the late 1970s. Together with an overall increase in numbers in work, this has resulted in a decreased actual population dependency ratio. The apocalypse may be a fantasy![7]

Chronological age *per se* does not predict an attenuated response to therapeutic intervention. The horse has not bolted! For example, the proportional reduction in further acute coronary events with statins after myocardial infarction is at least as good in older versus young individuals.[8] The proportional prevention of stroke, heart failure and premature mortality by treating hypertension is at least as good in the over 80s (other things being equal) as in younger people.[9] A major battle has long been to persuade the pharmaceutical industry to forego upper age limits in clinical trials (deployed on the pretext that the inevitable reduced efficacy in older groups might tarnish the marketing shine of their product!).

It is therefore crucial to distinguish ageing from

age-associated disease. For example, there is evidence that the prevalence of dementia in the older population is now declining.[10] Intuitively, this may reflect the positive cohort effects of evidence-based therapeutic intervention and lifestyle change on the vascular component of the condition.

Numerous advances in technical sophistication and risk reduction (eg enhanced and minimally invasive diagnostic imaging and surgical or cardiovascular intervention) may significantly benefit older people. Therefore timely access to such sophistication must not be withheld under the mantle of 'care closer to home'. When I was a house physician (F1) – admittedly in the early 1970s – my consultant encouraged reluctance to accept acute admissions over 65 on grounds they would block beds, and in most cases were probably beyond the pale or 'social'. Thankfully, by contrast, the British Orthopaedic Association now asserts (in harmony with NICE) that it's both cheaper and better to treat elderly hip fracture sufferers well (notably prompt surgery, physician collaboration, on-site multidisciplinary practice) than to do it badly (delay, prolonged non-operative management, protracted pain, dependency).[11,12]

'Joined up care' in line with population need is not an optional pipe-dream, not least because it is cost-effective.

Because advancing age confers some reduction in 'physiological functional reserve capacity', acute or ongoing health problems increasingly have wider adverse consequences for functional independence and personal and societal relationships; but these are transient and reversible till proved otherwise. Classic examples are problems of mobility or falling, problems of continence, and problems of cognition (notably delirium). To address this, individual medical, rehabilitative and social assessment and care for older people (*always, on site, and without delay*) need to happen together, crossing all boundaries and enabling efficient, shared, interdependent, mutually supportive teamwork, communication, continuity, coordination, training and accountability to take place.

Over the years, progressing from modest beginnings in isolated old workhouse infirmaries forward into the NHS mainstream, wherever this 'comprehensive' partnership principal has been fully implemented and organised, the results in terms of 'meeting the challenge of dependency' have been overwhelmingly positive for patients, carers, professionals and the system as a whole.[13,14] Importantly, that most expensive of NHS commodities, acute hospital bed occupancy, has been reduced without marginalising older people from that much needed environment.

Sadly and alarmingly, many contemporary trends are contrary, notwithstanding the rhetoric of 'joined-up care'. Social and health care, primary and secondary care, statutory and independent provision, have retrogressively divided. The continuing perennial instances of abuse or neglect within the burgeoning business market of social care, or of older people similarly languishing in hospital beds till their desperate relatives eventually extract them, reflect, at least in part, this fragmentation of the system, alongside inadequate multidisciplinary engagement and training.

Commercial incentives and an emerging pressure to keep older people out of mainstream acute hospitals (rather than equip the latter efficiently for demographic change) risk at worst re-inventing the concept of the old, dreaded, clinically marginalised workhouse infirmaries in glossy, sanitised forms. Instead of jointly owned responsibility, the 'alibi phenomenon' is rife; accountability always lies with someone else. Even from today's specialists in the medicine of ageing, the chorus 'we can't do it all' sounds out. True of course – but where else lies accountability? Robust clinician advocacy is required.

A centuries-long ethical heritage, safeguarded by a principled and balanced legal framework, must not be derailed by secularist ideology or economic pragmatism.

The age-old mantra that the moral health of a society can be gauged by the way it cares for its older generation still applies, and there are growing contemporary nuances that should stir us to unease as Christians in medicine.

The 'demographic time bomb' (that probably isn't!)[15] is widely mis-invoked to justify cost constraint as the primary principle, even when the historical evidence for cost-effective models of care is compelling. The fifth commandment[16] and its New Testament application[17] encapsulate intergenerational harmony and interdependence as rooted in the inestimable value of the individual in relation to God, the family and others. But dismissal of this heritage by secularist biological and economic pragmatists is insidiously surfacing in contemporary debate, whether concealed within the euphemism of 'assisted dying'[18] or within the recent invocation of 'economic productivity' as a component of the cost-benefit equation in therapeutic evaluation.[19]

Human longevity is identified biblically as a blessing, and we should celebrate the gift of its demographic realisation. But like all good gifts it presents both opportunities and challenges. Christian medics in the NHS need urgently to read the contemporary signals and be ready to respond:

Firstly, by loyalty to the truth (scientific and biblical) in our understanding and in influencing policy, secondly, by getting involved ourselves in professional practice and leadership in this field, and thirdly, by actively demolishing barriers of speciality, profession and organisational structure to ensure that every older patient we encounter has their needs met collaboratively, comprehensively and with Christ-like integrity.

Older people need tough (young) medical advocates. Are we up for the job?[20] 'Those involved in the NHS today are on the frontline of Kingdom activity'.[21] The rewards for ourselves of doing it well, as well as for society and for our witness to Christ, are tremendous. The long-term risks of not doing so may be very serious indeed.

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