A GERONTOLOGICAL STATISTIC*

DAVID PERK, M.D., D.P.M., JOHANNESBURG

The Witwatersrand Jewish Aged Home opened in June 1912, with 12 beds for residents. This represented approximately 1 per 4,000 of the estimated Jewish population of South Africa at that time (*circa* 50,000). In February 1958, when the Home transferred to newly-built premises, it accommodated 100 chronic sick and 125 residents, i.e. a total of 225 persons. By 1960 the number had increased to 240 sick and 220 residents, a total of 460, so that in the 48 years since the establishment of the first Home, the beds for the Jewish aged chronic sick available in this institution have multiplied by more than 40 times. The increase of beds is not only due to a larger population and an extended life-span. There are other factors which influence it.

For one thing, a heightened social conscience with regard to the aged has led to the establishment of the new Home, with double the accommodation it had before. For another, demand for beds, for one reason or another, soon catches up with supply. The accommodation provided in the new Home has won such widespread approval that it has encouraged many an aged person, or his family on his behalf, to seek admission more readily and timeously than previously. The increasing cost of living has also played a part in forcing aged persons, especially if requiring nursing care, to seek accommodation in a Home which gives preferential admission to the indigent. It is possible that the diminished reverence for authority and age that characterizes Western civilization of today may also play a part in the impetus behind the establishment and expansion of aged Homes that is being witnessed. The result of the factors mentioned has been that the new Jewish Aged Home has reached saturation earlier than was expected. It is easier to recognize the factors that have operated to fill the Home to capacity in retrospect than it was to anticipate them, and, even with clear anticipation, there are limits to which the present generation can be burdened with responsibilities that must belong, in some measure at any rate, to future generations.

The Jewish community of South Africa probably has a higher proportion of aged than the non-Jewish community. Of the total White population of the Union, according to the 1951 census, 6·5% were 65 years of age and over. The reason for the disparity in the ratio of aged to the total population of the Jewish and non-Jewish communities is largely that the Jewish community is now reaping the harvest of the wave of immigration from Eastern Europe, of youths in their teens and men and women in more mature years, that occurred in the years before World War I. In Table I it will be seen

TABLE I. COUNTRY OF ORIGIN OF APPLICANTS

Country	*No.*	*%*
Russia (pre-World War I)	155	77·5
England	16	8
South Africa	14	7
Germany	9	4·5
Austria	2	1
Israel	2	1
United States of America	1	0·5
Not stated	1	0·5
Total	200	100·0

that nearly 80% of the applicants for admission to the Home were born in Russia before World War I.

In looking back upon developments which the new Home has experienced since its inception, I am guided by particulars I have kept of applications for admission to the Home, it being my task to review these before they are considered by the lay executive of the Home. Choosing a date approximately nine months after the opening of the new Home (by which time, I considered, the applications held up for lodgment until the opening would have been presented and dealt with) I have analysed 200 consecutive applications filed thereafter. These cover the period from November 1958 to March 1960. The facts and figures set out in the various tables that follow throw indirect light on the composition of the Jewish community in South Africa in the early part of this century and provide an insight into the medical problems that are a by-product of age.

MARITAL STATUS AND SEX

Roughly two-thirds of the applicants are women (Table II). This is no doubt related to the greater longevity of women. A little less than half the male applicants are married; of the women only about one quarter are married. A quarter of the

TABLE II. MARITAL STATUS AND SEX

Status	*Male*	*Female*	*Total*	*%*
Widowers	19	88	107	53·5
Married	32	28	60	30
Single	17	9	26	13
Separated and divorced	4	3	7	3·5
Total	72	128	200	100·0

men applying are single, while only a small fraction of the women are single. Of the married men and women, 12 are couples who have not wanted to be separated in old age and illness, and about half the remaining married male and female applicants have sought admission because they could not get adequate nursing care at home. This leaves 9 married men and 7 married women whose applications throw a lurid light on the unhappy fate that awaits some marriages, fortunately very few, with the advance of years.

* Chairman's address to members of the honorary medical, dental and pharmaceutical panel of the Witwatersrand Jewish Aged Home, Johannesburg, on the occasion of the Eighth Annual Meeting of the Panel held on 14 August 1960.

These 16 sought admission because:

(*a*) The wife, being younger, preferred working to receiving assistance to keep up the home—2 cases;

(*b*) of more specific rejection (withdrawal by wife of second marriage, marital discord, lack of accommodation)—6 cases;

(*c*) the spouse was or felt unfit to look after the applicant—6 cases;

(*d*) of poverty—1 case; and

(*e*) of no stated reason—1 case.

MARITAL STATE, SEX AND DISABILITY

Neuro-psychiatric disturbances occur most frequently in the female single group and bodily disturbance most frequently in the female married group (Table III).

TABLE III. MARITAL STATUS, SEX AND DISABILITY

Sex and status	*Neuro-psychiatric condition*		*Bodily condition*		*Combination of neuro-psychiatric and bodily condition*		*Not stated*	
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Male married	7	22	9	28	6	19	10	31
Male single	4	23	6	35	2	12	5	30
Male widowed and divorced	3	13	10	44	3	13	7	30
Female married	4	14	13	47	7	25	4	14
Female single	4	44·5	1	11	4	44·5		
Female widowed and divorced	28	31	23	25	28	31	12	13

AGES OF APPLICANTS

Two-thirds of the applicants are 70 years and over, and about one quarter are 60—69. The single and divorced group constitute half of the under-60s and diminish to about $\frac{1}{8}$ of the over-70s. It is the reverse with the widowed group; they are a third of the under-60s and three-fifths of the over-70s. The number of married applicants is higher in the 60—69 group than in the other 2 age groups (Table IV).

TABLE IV. AGE DISTRIBUTION

	Under 60		*60 - 69*		*70 and over*	
	No.	*%*	*No.*	*%*	*No.*	*%*
Married	2	17	21	39	37	27
Widowed	4	33	23	43	80	60
Single and divorced	6	50	10	18	17	13
Total	12	100	54	100	134	100
% of total applicants	6		27		67	

Two-thirds of the under-60 applicants have a psychiatric disability. The youngest applicant was 43 years of age; she was a patient in the Witrand Institution.

ORIGINS OF APPLICATIONS

Five of the applications come from patients in mental hospitals, 1 from a mentally defective institution, 1 from a tuberculosis hospital, 3 from another Aged Home, 4 from psychiatric nursing homes and 24 from general hospitals. It seems fairly clear that the general hospitals have discovered a channel of disposal of the aged Jewish patients who have become invalids following an illness or injury which brought them to hospital. It means that the Home is being called upon to undertake the care of patients at a stage earlier than was the custom previously, with a resulting unexpected additional burden on its medical and nursing staff and on its finances.

AILMENTS OF APPLICANTS

Of the applicants, 31% of the males and 16% of the females, had no declared disability, either neuro-psychiatric or affecting other systems. These applicants required, in the main, either care or accommodation and company, and the male preponderance reflects the lesser ability of the senescent male to fend for himself as compared with the female. Neuro-psychiatric conditions occur twice as frequently in the female (60%) as in the male applicants (30%). Depression, senility and dementia are more common in female than male applicants (Table V). There is no significant difference between the sexes regarding other conditions. The frequency with which the more common

TABLE V. NEURO-PSYCHIATRIC CONDITIONS OF APPLICANTS

	Female		*Male*	
	No.	*%*	*No.*	*%*
None stated	53	41	48	67
1. Confused reaction of the aged	20	16	8	11
2. Vascular lesions of brain, including premonitory symptoms, such as vertigo and blackouts, and paralytic sequels	15	12	9	12·5
3. Depressions (including agitation and suicidal attempts)	12	9	1	1
4. Senility	12	9	4	5·5
5. Dementia	8	6	2	3
6. Parkinsonism	6	5	5	7
7. Psychoneurosis	5	4	0	0
8. Paranoid state	4	3	0	0
9. Mental retardation	3	0	0	0
10. Paraplegia	1	0·8	0	0
11. Epilepsy	1	0·8	0	0
12. Cerebral palsy	0	0	1	1
13. Hypertensive encephalopathy	1	0·8	0	0
14. Undiagnosed psychiatric conditions	1	0·8	0	0

neuro-psychiatric conditions are mentioned in the applications pursues the following descending order (the figures given in brackets are percentages): Confusional reaction of the aged (14), vascular lesions of brain, including premonitory symptoms (12), senility (8), depression (6·5), Parkinsonism (6·5), and dementia (5).

Each application is accompanied by a medical questionnaire which is completed by the private medical attendant of the applicant. The information supplied by these questionnaires is, generally speaking, sparse, but it has the merit of highlighting the outstanding clinical features presented and a number of clinical entities, which are solely nosographic, are as a consequence readily discernible. Several of the diagnostic labels I have appended to these entities call for definition. Confusional reaction of the aged is a temporary, usually recurrent condition, showing disorientation, impairment of memory, emotional lability, a tendency to paranoid misconceptions and misconstructions, restlessness and noisiness frequently more pronounced nocturnally, and a tendency to wandering from home. Senility is a chronic, unremitting condition manifesting impaired memory, emotional lability, personality disorganization and physical feebleness less severe than dementia.

Bodily disturbances are about $2\frac{1}{2}$ times more frequent in

the female (72%) than the male applicant (29%). Hypertension and arthritis figure significantly more commonly in the case of female applicants (Table VI).

TABLE VI. BODILY AILMENTS OF APPLICANTS

	Female		*Male*	
	No.	%	*No.*	%
None stated	36	50	51	40
Hypertension	26	20	1	1
Cardiac conditions	17	13	8	11
Diabetes	17	13	7	10
Malignancy	9	7	6	8
Reduction of vision or hearing (from all causes)	8	6	6	8
Arthritis and osteoporosis	7	5·5	1	1
Fracture of neck of femur and residual disabilities	6	5	0	0
Disease of respiratory system	5	4	0	0
Hernia (abdominal, inguinal or hiatus)	3	2	2	3
Prostate trouble	0	0	7	10
Varicose veins, thrombosis, ulceration	2	1·5	2	3
Bedsore	0	0	3	4
Alcoholism	0	0	1	1
Peptic ulcer	1	0·8	1	1
Peripheral neuritis	1	0·8	1	1
Other conditions	9	7	1	1

Bodily ailments show the following incidence in the applications (the figures in brackets are percentages): hypertension (13·5), cardiac conditions (12·5), diabetes (12), malignancy (7·5), reduced vision and hearing (7), disease of the respiratory system (4·5), arthritis and osteoporosis (4), prostate troubles (3·5), and fracture of the femur (3). Other conditions occur infrequently.

Of the applicants, 8% have more than 1 neuro-psychiatric disability and 10% more than 1 bodily disability. Parkinsonism is associated with each of the following—confusion, senility, dementia and depression; hemiplegia with confusion, depression and cerebral tumour; dementia with confusion and depression; senility with confusion; and paranoid state with depression. Hypertension is associated in most instances with diabetes, confusion or hemiplegia, and in single instances with senility, dementia, encephalopathy and hysteria. Diabetes is associated with a psychiatric state in 20%, with hypertension in 16%, with cardiovascular conditions in 13% and with complications of diabetes (gangrene, retinitis, bedsore, peripheral neuritis) in about 20%. The association with other conditions, by comparison with the foregoing, appears fortuitous.

Of the 200 applicants, 99 have a neuro-psychiatric disability, 113 a disability in other parts of the body, and 50 a combination of both.

STATE ON ADMISSION

Of the 200 applicants, 41 required care in bed on admission because of either sickness or a degree of enfeeblement which rendered them virtually helpless out of bed. The following conditions reduced them to bed care on admission: coronary thrombosis and congestive cardiac failure, 13; cerebral thrombosis and hemiplegia, 8; senility and dementia, 8; diabetes and complications, 4; malignancy, 3; orthopaedic disabilities, 2; respiratory disorders, 2; and hypertension, 1.

REASONS FOR ADMISSION

The reasons for seeking admission fall into a number of categories and speak for themselves. They are:

1. Need for (*a*) nursing care of a bodily condition that domestic or financial circumstances make it impossible to provide at home, and (*b*) company and nursing care of a bodily condition, in instances of social isolation, 116 (58%).

2. Hospitalization for a neuro-psychiatric condition, where nursing care is secondary to the need for hospital domiciliary care, 61 (30·5%).

3. Need for (*a*) accommodation and (*b*) support, 9 (4·5%).

4. To be with a spouse or, in 1 instance, a mother who needed admission under 1 and 2 above, 5 (2·5%).

5. Marital discord, 4 (2·0%).

6. Sundry (pulmonary tuberculosis, a period of rest from nursing an ailing spouse, vaguely stated), 5 (2·5%).

It will be seen from the above that little short of a third of the applicants present psychiatric problems calling for psychiatric beds and psychiatric care. Of the applications 80·5% were recommended for admission by the medical advisory committee (the lay executive makes the final decision); 10% for admission, subject to an undertaking signed by a member of the applicant's family to remove the patient if found unsuitable for the Home; 2% for admission on special conditions; and 7·5% to be refused admission. There were various reasons for recommending the rejection of certain applications. They were:

1. Unsuitable psychiatric cases, already hospitalized, 5.

2. Unsuitable psychiatric cases, not hospitalized (epilepsy with confusion, 1; simple-minded spastic, 1; disturbed paranoid dementia, 1), 3.

3. Inadequate medical grounds for admission (uncomplicated hypertension in a person of 63 years of age, 1; hysteria in a person of 55, 2; open tuberculosis of lung, 1; person of 57 with no disability, 1), 4.

4. No medical grounds for admission (marital discord, 2; others 1) 3.