SOCIAL GERONTOLOGY AND SOUTH AFRICA

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In the Republic of South Africa only the White section of the population is ageing.[1] The economic and social implications of this are very complex, and cannot as yet be accurately measured. Since little work has been carried out in this field of study in South Africa, one can only indicate the trends and point out some of the more important gaps in our knowledge.

The implications of the presence in the community of a larger, more rapidly increasing and younger Bantu population in such close proximity to the much smaller, slow-growing and rapidly ageing White population are very complex and form the basis of a separate investigation.

For convenience, the subject matter will be divided into separate facets, although it must be accepted that they influence one another greatly. All sections of this paper refer only to the White population of South Africa.

AGEING OF THE POPULATION AND THE LABOUR SUPPLY[2,3]

It is evident that the size of the population, its age, sex and urban-rural composition, play important roles in determining the size and structure of the potential economically active population.

The potential labour force may be considered, for convenience, as equivalent to the population between the ages

of 15 and 64. In the Republic of South Africa this group showed a proportionate increase from 61·2% in 1911 to 63·9% in 1936, followed by a steady decline to 60·84% in 1960 (Table I).[4-6] Alsop[7] expressed the view that the decline would be a long-term one, with the possible development of a shortage of labour to meet the needs of expanding industries.

Nearly all males work gainfully during adult life until the age of retirement and therefore form the main labour force. Demographic factors are the principal determinants of the size of the male population and hence the labour force. The numbers of women, and the young and old persons in the economically active population are, however, affected by a large number of non-demographic factors.

TABLE I. WHITE POPULATION OF SOUTH AFRICA, EXPRESSED IN PERCENTAGES[4-6]

Age groups	*1911* %	*1921* %	*1936* %	*1951* %	*1960* %
0 - 14	36·4	37·1	31·2	31·7	32·47
15 - 64	61·2	59·3	63·9	61·8	60·84
65 and over	2·4	3·6	4·9	6·5	6·68
15 - 44	49·8	45·1	47·5	45·0	42·24
45 - 64	11·4	14·2	16·4	16·8	18·60
	61·2	59·3	63·9	61·8	60·84

Associated with ageing at the apex of the population pyramid, as in other industrialized countries, there is an increase of the upper middle-age group, i.e. those between 45 and 64 years. This group showed a proportional rise from 11·4% to 18·6% between 1911 and 1960 (Table I).[4-6] This trend has therefore been reflected in ageing of the labour force. It will continue and will probably become more rapid after 1980.[7]

Older workers are less easily retrained for new jobs requiring different skills and are considered less adaptable than younger workers. They are therefore less able to change occupations, and with an increasing proportion of older workers there is likely to be a reduction of both occupational and geographic mobility.[2,3]

Coupled with this, and, perhaps more important, because of its effect on the labour-force potential and its economic implications, is the marked decline in the labour-force participation by the older age groups.[8] Between 1921 and 1951, in the age group 55 - 59, the percentage of men in the labour force dropped from 95·95% to 92·19%, and in the age group 60 - 64 it dropped from 92% to 78·15%. The groups above 65 showed even bigger declines. In the urban areas, compared to the rural areas, there is not only a later entry into the labour force, but also an earlier withdrawal.[8]

Kruger[9] made the following observations:

'. . . It is clear that the unemployed above the age of 45 years constitute a substantial problem. The main reason is not that so many persons above the age of 45 lose their jobs, but that they are in fact difficult to place.'

The majority of the older unemployed workers are semi-skilled or unskilled. They are not able, therefore, to do the heavy physical work often required of them. They are also the least adaptable of the older workers.[9]

Little is known of the effects on the size and composition of the labour force of such factors as capacity, performance, health, education and vocational guidance, working time offered and the attitudes of employers and trade unions. The factors which influence the entry and withdrawal from the labour force of women are even more complex.

For the active labour force to keep up with the possible expansion of industry, the above trends will have to be halted or reversed. More workers will have to be absorbed from those not participating to any great extent at present, particularly from the women and older men.

The prevention of unnecessary waste of manpower in South Africa, through premature voluntary or forced retirement of men who may still be able to make a valuable contribution as workers, has still to be studied.[10] With the retention of the opportunity for and flexible conditions of work, vocational retraining and rehabilitation programmes, and the selective placement of workers, it may be possible to achieve a gradual transition from an active to an inactive life, with reduction in work in proportion to the older workers' abilities.

EFFECTS ON THE ECONOMY AND THE NEED FOR COMMUNITY SERVICES[2,3]

Population growth tends as a rule to increase the requirements of commodities and social services to meet the needs and wants of people. Since labour is a fundamental factor in production, the effect of a declining and ageing labour force can be appreciated.

Population changes may influence the *per capita* output and standard of living through their effects on human and material resources, economic and social conditions, and external economic relations.[2,3] The factors governing these levels and trends still need to be assessed.

The economic gains in the twentieth century associated with industrialization have not been shared by all age groups. It would seem that the present economic status indicates a failure of the older age group to keep pace with the overall advances of the other groups.

Coupled with these changes is the considerable diminution of the average expected working life of persons over the age of 50. With the steady increase in the life-span, the period lived in retirement, therefore, has been increasing. This is more noticeable in the urban areas where there is earlier withdrawal from the labour force than in the rural areas.[8]

The old-age dependency burden has, therefore, been greatly increased in South Africa. This has been aggravated by the decrease of the real value of savings and by the general rise in prices, which is primarily the result of non-demographic factors.

The Committee on Economic and Financial Problems in Britain stated:

'It is in the fact of dependence that the major economic and financial problems of old age originate. The economic problems are those that result from the need to accumulate or free resources out of which adequate provision can be made for the old; the financial problems arise out of the need to transfer to the old the purchasing power that will give them the appropriate command over those resources. If everyone was to set aside enough during working life to provide for old age, the financial problem would be solved, although the economic

problems would remain of using resources saved today in order to yield income tomorrow. But most people do not reach the age of retirement with ample accumulated savings.'

In South Africa, the most important economic aspect of this dependency problem is the cost of social-security benefits in the form of pensions and grants. The size of these benefits and the conditions attached to them are the major factors determining the total amount spent. Some 214,000 social pensions and grants are paid out monthly, the annual expenditure amounting to R48,000,000.[12] This is by no means a measure of the total cost to the community, for whatever an aged non-worker consumes, whether it be financed by his own savings, by his children, by life insurance, or by public or private funds, is a drain upon the producing population. This tends to reduce the standard of living of the remainder of the community.

The increased and changing needs for various social services, health services, housing, and provision for leisure for the aged, are also important factors in the problems of public finance. These needs are at present being met to a certain extent by their children, by other relatives and friends who are willing to stand by them, by voluntary charitable organizations, and by the State and local authorities. The extent and character of these needs and the determination of standards of adequate care and facilities for old people are still to be assessed.

There is widespread agreement that it is generally economical to provide community services to help keep old people in their own homes. When old people live near their relatives or children they usually receive many important personal services from them. As they become frail and unable to care for their own personal needs, perform the normal activities of daily living, find social contacts in the community around them and maintain their financial independence, additional assistance must be provided if they are to remain independent. The general trend, however, has been the substitution of family contributions by those of public organizations, either State or voluntary.

The growing proportion of the electorate receiving old-age pensions or public assistance makes it more difficult for the authorities to ignore claims for higher benefits. The cost per aged dependent, therefore, tends to rise. This increase in the public expenditure for the aged is not compensated for by the decrease in the proportion of juvenile dependents, since the State normally assumes a much smaller share of the financial responsibility for the support of children than of the aged.

During the past 10 years most Western European countries have been developing systems of interrelated and coordinated services to prolong the period of usefulness, health and independent living of old people.[13] These include domestic-help services, meals-on-wheels schemes, home health visiting with emphasis on prevention and rehabilitation, chiropody services, provision of glasses, hearing aids and appliances, the formation of social clubs, and employment in limited supervised fields. Voluntary organizations and social agencies have taken on most of this work with or without Government financial assistance.

The community, therefore, is confronted with heavy budgetary burdens as a result of the absolute and relative increase in the numbers of old people, which may increasingly restrict the allotment of funds for new development in other fields.

The direction and the rate of social, economic and political progress have still to be investigated to clarify the possible effects of ageing in South Africa upon such indices as industrial efficiency and productivity, development of capital equipment, fullness of employment, and the behaviour and motives of consumers and investors.

To summarize, the ageing of the population is said to depress levels of living by:[2]

1. Increasing the burden of dependency.
2. Reducing the efficiency as well as the relative size of the working population.
3. Increasing the risk of unemployment.
4. Disturbing the pattern of consumption in relation to investment.
5. Retarding economic, cultural and political progress.

To counter the mounting costs and in order to reduce the drain on public funds and resources generally, consideration has been given to raising the agé at which a person qualifies for a pension. Perhaps more important is the prevention of the unnecessary waste of manpower through premature retirement of men who may still be able to make a valuable contribution as workers. This concept requires further detailed study in South Africa.

IMPACT OF AN AGEING POPULATION ON HEALTH AND HOUSING FACILITIES

Through repeated reiteration over the years, certain misconceptions have become accepted as fact by both medical and non-medical bodies interested in social and medical gerontology. Before considering the possible impact of ageing of the population on health and housing facilities in South Africa, it is necessary to clarify several important points.

The expectation of life can be looked on as the average lifetime to be expected by a person of a particular age if subject to the death probabilities of a specific period. It is derived from life and mortality tables and is a measure of past mortality changes.

In South Africa, over the period of 29 years from 1918, there was a global reduction in mortality of 30%.[14] In the age group under 30 it was more than 50%. In the older age groups, however, the relative and absolute decrease in mortality, and hence the saving of lives, diminished. The decline in mortality among those aged 55 and over was very slight indeed. Fig. 1 illustrates the small gains in the expectation of life of the older age groups in contrast to the younger age groups.

The statement that older persons are living longer and that this is one of the main causes of the ageing of the White population is, therefore, only partially true. It is

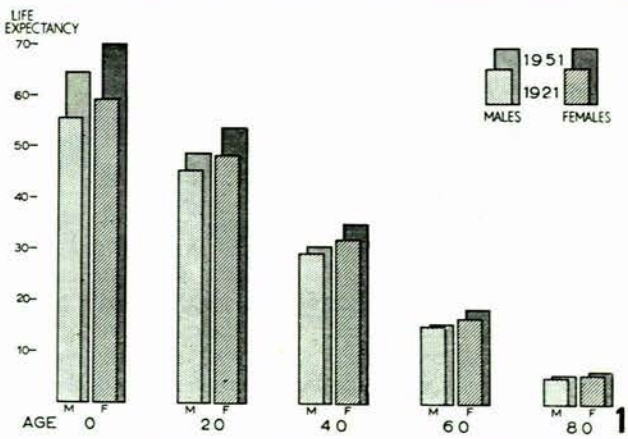

Fig. 1. Increase in life expectancy between 1921 and 1951 in Whites in South Africa at different ages.

the decrease in mortality and the resultant increased survival of the infants and younger age groups from the turn of the century which is the most important cause of the increase in the numbers of old people in the present population.

The decreases in mortality took place even before the introduction of antibiotics. The falling death rates are a tribute to the effectiveness of modern methods of control of infectious and epidemic diseases, and of programmes of health education and medical care. The expectation of life can therefore also be looked on as a measure of the standards of health, in order to compare past and present positions.

However, the full part played by the decreased mortality and by the decreased fertility and birth rates in the absolute and relative ageing of the population of the Republic of South Africa have still to be assessed.

CHANGES IN FAMILY LIFE

Every community needs to study its own cultural, economic, industrial and demographic conditions before drawing conclusions about the present situation and future developments. This is particularly true when reference is made to family life in South Africa. It has often been said, and is now accepted in many circles, that the three-generation household pattern of living of previous years is breaking up because of the unwillingness of the children to shoulder their family responsibilities. Because of this disruptive effect on the family, institutional arrangements have to be made for the care of the old and of handicapped parents.

This statement, however, does not take into account the separation and break-up of family groups by migration to the cities, which has been taking place on such a large scale for many years.[15] People migrate as conjugal or nuclear families or establish themselves as such. This has become the most prevalent family type in the cities and towns.

In addition urbanization and industrialization has placed the emphasis on individual ability, geographic mobility, separation of work and home-life, and the employment given to women outside the home. These trends have established the ideas of individualism in all age groups.[15] This has probably spread even to the rural communities.

A further factor of great importance in the separation of the members of the close-knit three-generation household is that the present size and character of urban housing units limit the number of persons who can live in a single household. The ability to take in aged or disabled persons is thus also limited.[15]

The social survey[16] of persons over the age of 60, carried out in 1958 in South Africa, showed that 5·3% were never married and a further 6·0%, although married, had no children. If one adds to this group of 11·3% the aged who live some distance from their children or close relatives, it will be apparent that the number who have to depend on strangers during a period of need becomes considerable. It is therefore surprising that only 5% of the whole group is receiving institutional care at present.[12,16]

While the family pattern has changed rather than broken up under the influences mentioned above, one finds that the relatives and neighbours still play an important part in family life. The ties have, however, become loose and informal. The social survey[16] showed that about 60% of people over the age of 60 are in close and daily contact with relatives and friends. The functions taken over by society are no less important now than in the past, when they were still part of the family responsibility.

One must therefore, agree with Sheldon's[17] view that 'the strongest indication that the ties of kinship are still operative lies in the fact that the community is able to manage at all, for a real abdication by the younger generation from the care of their old people would completely submerge our present resources'.

This individualism and consequent change in conjugal family life has resulted in an increase in the number of independent units or households. With ageing of the population and an increase in the numbers of widows and widowers living as independent units, the need for low-cost housing increases.[2,15]

HOSPITAL NEEDS

The need for hospital and ancillary services must depend primarily upon the range, character and extent of illness found in the community, and the utilization of the services provided. The needs obviously vary with age.

In the higher age groups degenerative diseases predominate and are often multiple. The frequency and the period of illness also increase with age. This increased breakdown in the health of the elderly is at present inevitable. On the whole, more doctors, more medicaments and more hospital beds are required for old people than for young adults.[2,3,12,18]

The medical services will face a growing burden of chronic invalidity arising from sheer growth in numbers of old people[19] (Table II). Sheldon[17] emphasized that even more important than this is the rapid growth in the number of persons in the second half of old age. Most people over the age of 75 will need medical, nursing and domestic help intermittently, continuously or only terminally. With modern medical facilities and antibiotics the period of final incapacity is also increased.

TABLE II. WHITE POPULATION OF SOUTH AFRICA, OVER 64 YEARS OF AGE[4,6]

Age groups	*1936*	*1951*	*1960*
65 - 74	72,441	116,177	134,630
75+	26,654	54,783	70,685

The numbers of medical practitioners and hospital beds per unit of population and the numbers of treatments given are not indications of the extent of fulfilment of such needs or of the health of the population.[15] They give no indication of the distribution and utilization of these facilities in relation to the total health service and the requirements of the community.

Calculations in the Republic of South Africa are based on figures from other countries. These calculations take little or no account of the comparative underdevelopment (or even absence in some areas) of such services as home-care programmes, health clinics, domestic assistance, and hospital and institutional facilities for the care of the chronic, elderly or long-stay patients.

Large numbers of disabled elderly persons have inadequate facilities for home care. Many patients in the acute general hospitals of Johannesburg do not require inpatient care and their admission could have been prevented by extension of social and medical facilities to their own

homes.[19] The most unfortunate aspect is that the hospital departments become involved in the continued care of these patients, with a resultant waste of effort and money.

The provision of services itself leads to changes in attitudes and to greater demands for medical advice and hospital care. In planning, little allowance has been made for future changes in the role of the hospital, the doctor, the auxiliary personnel and the standards and character of medical care.

It becomes important, therefore, to obtain information about the prevalence of disease and disability, the utilization of medical services and hospital beds, and the pattern of behaviour of chronically ill persons. This information may then be correlated with economic, social, cultural and demographic findings in South Africa itself. In the light of these findings a comprehensive medical and geriatric service, which will be suited to the community concerned, can be established. This service may include domiciliary and hospital services providing for prevention, diagnosis, treatment, rehabilitation and continuing care of older people.

SUMMARY

In the Republic of South Africa, only the White section of the population is ageing. The associated ageing and decline of the potential labour force may hamper future expansion of industry. The marked decrease in participation of old people in the labour force, together with the difficulty of retraining and placement of older workers, as at present, will aggravate the position.

The demand for adequate and low-cost housing, and social, medical and hospital services, is probably increasing. The change in the structure of family life will increase the dependency burden of the community. This will be a drain on both private and public funds and resources and may possibly restrict development in other fields.

Some of the more important gaps in our knowledge of the conditions prevailing in South Africa are also indicated.

The effects of the presence in the community of a larger more rapidly growing and younger Bantu population in such close proximity to the much smaller, slow-growing and rapidly ageing White population are still to be studied.

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