OLD PEOPLE LIVING IN DORSET

A SOCIO-MEDICAL SURVEY OF PRIVATE HOUSEHOLDS

BY

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The present investigation is part of a more comprehensive study of old people living in Dorset (Simonds, 1954). The main survey, which was sponsored by the Health and Social Services Committee of the Dorset County Council, had as its immediate objectives:

(1) to discover the extent and nature of latent welfare needs among old persons living in the county;

(2) to decide which of the permissive clauses in Part III of the National Assistance Act (where the responsibilities of the local authorities towards disabled, infirm, and aged persons are outlined) should be recommended by the Health Committee.

The facts required were partly medical and partly social, and three categories of old people had to be considered:

- (i) inmates of institutions for the aged,
- (ii) tenants of almshouses, bungalows, and flats reserved for the use of old people,
- (iii) tenants or owners of other dwelling houses.

Only the findings in respect of the third group are described here.

CHOICE OF SAMPLE

At the time of the Survey the most up-to-date estimates of the sex and age distribution of the civilian population were those for December 31, 1947 (General Register Office, 1949). According to these, a random sample of 500 persons over the age of 65 in the Administrative County of Dorset would have included approximately 212 persons from the large towns (over 30,000 inhabitants), 104 from smaller towns, and 184 from rural districts. By placing these three types of locality in order of population density and applying the block number method of random selection (Yates, 1949), six localities were chosen to represent the county. These were Poole and Weymouth (representing large towns), Dorchester and Swanage (smaller towns), and Wimborne and Wareham (rural districts).

The National Register had been withdrawn before the survey began. It was necessary, therefore, to obtain the

500 old persons indirectly through the Rating Valuation list of houses. The random sampling procedure, which is described in detail elsewhere (Simonds, 1954), aimed at obtaining 54 interviews with old persons living in municipally owned houses, 332 with old persons in private houses rated at £20 per annum or less, and 114 in private houses of higher rateable value. It did not, however, allow for the fact that the official housing policy is heavily weighted against old persons. Consequently even a calculated excess of houses failed to produce the fixed quota of old persons in municipally owned houses (Table I). The number of successful interviews was further reduced for the following reasons:

Reason for Not Interviewing	Men	Women
Interview refused	7	10
Moved house*	6	13
Died	6	10
General practitioner's advice† ..	1	2
Admitted to hospital for life ..	1	2
Under 65 years	3	7
Total	24	44

* The interval between identifying the houses which contained old people and calling on them ranged from 3 to 12 months.

† In every case the General Practitioner was consulted before seeking an interview.

Eventually 172 men and 282 women were interviewed in their homes by one of us (W.H.S.) and facts collected under the following headings were recorded on standard schedules:

- Age, civic status, past and present occupations;
- Age and reasons for retirement;
- Birthplace and period spent in present locality;
- Detailed specification of house and fellow occupants;
- Feeding habits, income, and recreations;
- Any operations, illnesses, and accidents which had caused residual disability or had occurred since the age of 60;
- Current symptoms;
- Medical assistance received during the last 12 months.

SOCIAL DATA

The ratio of males to females and the average ages of the men and women (Table I) were much the same as the 1951 Census Estimates for the Southern

Region (General Register Office, 1954). There were, however, within the survey group relatively more women and less men among the under 70s and over 80s than in the middle age group (Table II). The

TABLE I
SELECTION OF SURVEY GROUP FROM RATING VALUATION LIST OF HOUSES

Region	Housing Grades*	Fixed Quota of 500 Persons over 65 years	No. of Houses on Sample Address List	No. of Old Persons living in These Houses	No. of Successful Interviews	
					Male	Female
Large Towns	1	25	69	18	6	11
	2	127	275	130	46	68
	3	60	149	68	24	36
	Total	212	493	216	76	115
Small Towns	1	13	39	12	4	7
	2	61	130	71	21	40
	3	30	70	35	11	19
	Total	104	239	118	36	66
Rural Districts	1	16	50	7	3	4
	2	144	305	147	48	82
	3	24	61	34	9	15
	Total	184	416	188	60	101
All Regions	1	54	158	37	13	22
	2	332	710	348	115	190
	3	114	280	137	44	70
	Total	500	1,148	522	172	282

- * (1) Municipally owned houses.
 (2) Other houses with rateable value of £20 p.a. or less.
 (3) Other houses with rateable value over £20 p.a.

TABLE II
COMPARISON OF SURVEY GROUP WITH 1951 CENSUS ESTIMATES

Data		Survey Group		1 Per cent. Census Sample, 1951 (persons over 65 yrs)	
		Male	Female	Male	Female
Sex Ratio		1 : 1.6		1 : 1.56*	
Average age (yrs)		73.1	73.0	72.8	73.6*
Marital Status	Partner over 65	45.3	27.6	}	67.4
	Partner under 65	20.4	7.2		34.3*
	Partner deceased or separated	27.9	44.3		47.1*
	Single	6.4	20.9	9.0	18.6*
Social Class	I and II	24	—	24	—
	III	40	—	44	—
	IV and V	36	—	33	—
Income	Still gainfully employed	19.8	6.4	34.5	9.5†
	Receiving state pension	74	69	66	67‡
Companionship	Alone	5.8	18.1	2.9¶	
	With over 65s only	33.6	33.6	—	
	With younger generation/s	20.4	28.4	—	
	Single household	17.9		13.7¶	
Housing	Fixed bath	Urban	73	72**	
		Rural	46	58**	
	W.C.	Urban	99	93**	
		Rural	46	65**	

* Southern region (** all households in Southern region). † Great Britain. ‡ From third report of Ministry of National Insurance.
 ¶ All households in Great Britain.

survey group also appeared to be representative of the Southern Region in respect of the number of married persons and the social class distribution of the men, but compared with the country as a whole it contained an exceptionally high proportion of spinsters and retired men in receipt of State pensions.

HOUSING.—Comparisons between all houses in the Southern Region and the survey houses showed that the old people living in towns were well supplied with fixed baths and W.C.s, but that the rural dwellers were at a disadvantage in these respects.

A more detailed picture of the survey houses can be obtained from the figures shown in Table III. According to these there was no evidence of overcrowding, but nearly 20 per cent. of the rural houses were grossly substandard in respect of structure, fixtures, and furnishings. Assuming that the survey group is typical this suggests that the villages of Dorset contain nearly 2,000 such houses occupied by old people. The corresponding estimate for the towns is in the region of 200.

TABLE III
LIVING CONDITIONS

Household Amenities		House Score	No. of Houses	
			Urban	Rural
Water Supply and Drainage	Bath and W.C. ..	+5	164	48
	Bath only ..	+2	—	6
	W.C. only ..	+3	57	6
	Neither ..	0	3	56
Dangerous Staircase		—1	29	16
Structure of Building	Satisfactory ..	+3	155	55
	Needing minor repair ..	+2	49	35
	Needing major repair ..	+1	20	26
Telephone		+1	45	23
Furnishings	Generous ..	+3	59	16
	Adequate ..	+2	109	44
	Poor ..	+1	56	56
Density Ratio*	More than 1 room per person ..		194	97
	One room per person ..		15	17
	Less than 1 room per person ..		15	2
House Score (see col. 2)	9-12 Good ..		121	41
	5-8 Satisfactory ..		82	13
	3-4 Barely adequate ..		18	42
	0-2 Grossly sub-standard ..		2	20
Total Houses ..			224	116
Total Persons ..			293	161

*House score (—1) if the old persons have no room to themselves.

RETIREMENT DATA (Table IV).—At the time of the survey, one-fifth of the men were still in paid work, of whom approximately one-third had recently changed to a less strenuous occupation. Less than 25 per cent. of the men had retired before the age of

65, and over 50 per cent. had continued working after this age. Among the retired men (138) were 55 who had held jobs with a fixed age of retirement and 62 who had been forced to retire by ill health.

Within the much smaller group of women who had been in paid employment (106), only 54 had continued working after the age of 60, and thirty had had to give up work for reasons of health.

TABLE IV
RETIREMENT

Data		Male	Female
Still in paid work	Usual employment ..	25	18
	Recent change ..	9	—
Retired	Before statutory age*	41	41
	At statutory age ..	41	11
	At later date ..	56	36
Reasons for retirement	Ill health	62	30
	Own choice	21	33
	Fixed age of retirement ..	55	25
Housewives and others not gainfully employed ..			176
Total		172	282

* 65 for men, 60 for women.

FINANCIAL CIRCUMSTANCES.—Approximately one-quarter of the men and one-third of the women who were interviewed had made no attempt to claim their old age pensions. A further 58 per cent. of the men and 47 per cent. of the women had private incomes which they combined with their statutory allowances, leaving only 28 men and 57 women who were financially dependent on the State. In this group half the men and three-quarters of the women had successfully claimed supplementary allowances. Only three persons (all women) refused to disclose the source of their income.

DOMESTIC ARRANGEMENTS AND DIET.—The proportion of old persons who could rely on a fellow resident for domestic help was higher for the men (89 per cent.) than for the women (50 per cent.), and slightly better for the town dwellers (68 per cent.) than the villagers (55 per cent.). Several women still ran their houses unaided, and were content to know that relatives or friends were available for emergencies. There were, however, five men and 29 women who were unable to say what would happen in such an event. In the vast majority of cases relatives or friends did what extra domestic work was required, and there was no question of direct payment for services. There were, however, fifteen men and seventeen women who could afford to pay for—and had obtained—a resident maid or housekeeper.

Where the husband was on the retired list it was customary to find him doing some of the day-to-day work about the house, but the frequent exceptions to this rule are reflected in the finding that 61 per cent. of the women did all the household cooking and shopping and a further 12 per cent. did all the cooking and most of the shopping. Among the men, 57 per cent. had neither shopped nor cooked and a further 26 per cent. only shopped occasionally.

For the group as a whole feeding habits appeared to be satisfactory. There were, however, a small number (six men and fifteen women) who were on special diets prescribed by their doctors and a still smaller number (six men and ten women) who habitually took uncooked meals of the "bread and marge" variety. Of the latter three lived alone and seven were said to be either eccentric or mentally subnormal.

LONELINESS.—In answer to a direct question eight men and 52 women admitted that they felt lonely. For persons under 80 years of age this group represented 2 per cent. of the men and 16 per cent. of the women. Above this age it included 16 per cent. of the men and 27 per cent. of the women. Among the men there was no significant difference between villagers and town dwellers, but among the women loneliness was distinctly more common in the rural areas. As might be expected this particular complaint was rare among the old people who were living as man and wife and relatively common among those who had recently moved into the district.

MEDICAL DATA

On the basis of what the general practitioners had to say about their patients and what was noted at the time of the interview, each person was placed in the appropriate physical, mental, and prognostic grade.

PHYSICAL GRADES

Grade 1.—All persons who, in addition to appearing fit, were both free from minor disabilities (*e.g.* bunions, callosities, varicose veins, hernia, moderate deafness, impaired vision, etc.) and had not experienced any illness which was likely to recur or lead to other troubles (*e.g.* raised blood pressure, recurrent attacks of bronchitis, arthritis etc.). Loss of teeth was not regarded as a disability provided adequate substitutes were in use.

Grade 2.—As for Grade 1, except for the existence of minor disabilities.

Grade 3.—All other persons who appeared to be in good health at the time of the interview.

Grade 4.—Up and about but unable to go far alone and not fit to do their own housekeeping.

Grade 5.—Periodically or permanently confined to bed.

MENTAL GRADES

Grade 1.—Reasoning powers, personality, and memory all sound.

Grade 2.—Reasoning powers and personality sound, but noticeable loss of memory.

Grade 3.—Rational but liable to upset fellow occupants, etc.

Grade 4.—Irrational.

PROGNOSTIC GRADES

Grade 1.—Likely to remain in good health for some time.

Grade 2.—Apparently fit but prognosis uncertain.

Grade 3.—Manifestly unfit and unlikely to recover.

By all three criteria the men were clearly more fit than the women (Table V). These sex differences tended to increase with the years, and after the age of 80 there was five times as much physical invalidism among the women as among the men, and nearly three times as many instances of mental disorder. In the higher mental and physical grades the sex differences were less marked than in the lower grades, and when all disabilities and age groups were merged the good prognostic indications were nearly as common among the women as among the men.

TABLE V
PHYSICAL, MENTAL, AND PROGNOSTIC GRADES

Grades		Male				Female			
		60s	70s	80s	All Ages	60s	70s	80s*	All Ages
		No.	No.	No.	Per cent.	No.	No.	No.	Per cent.
Physical ..	1	22	22	7	29.7	25	37	6	24.2
	2	14	19	4	21.5	27	32	5	22.6
	3	12	31	9	30.2	27	38	9	26.2
	4	4	21	4	16.9	5	32	16	18.8
	5	1	1	1	1.7	4	7	12	8.2
Mental ..	1	36	54	17	62.0	53	76	21	53.2
	2	15	37	6	33.3	28	65	19	39.7
	3	2	2	1	3.5	6	4	6	5.7
	4	—	1	1	1.2	1	1	2	1.4
Prognostic. .	1	34	40	11	49.4	56	65	13	47.5
	2	14	30	7	29.6	20	45	7	25.5
	3	5	24	7	21.0	12	36	28	27.0
Totals ..		53	94	25	100	88	146	48	100

* Including three women over 90.

PRINCIPAL DEFECTS, TEETH, AND OTHER SYMPTOMS.—Systematic questioning elicited the number of persons who suffered from certain well-known complaints of old age. These answers, together with the histories of illnesses, accidents, and operations and the reports from general practitioners, made it possible, in a given case, to decide which of fifteen

"principal defects" (allowing only one for each person) was causing the most trouble (Table VI). In practice, eight of these headings sufficed for over 85 per cent. of the group.

TABLE VI
PRINCIPAL DEFECTS, TEETH, AND OTHER SYMPTOMS

Defects*		Percentage		Number of Persons
		Males	Females	
Principal Defects	Nil	26.1	20.5	103
	Cardiac	12.7	17.4	74
	Locomotor .. .	8.2	17.7	67
	Visual	10.4	7.8	40
	Pulmonary .. .	6.8	6.7	31
	Gastric	6.6	5.7	27
	Auditory	6.6	5.4	26
	Personality .. .	3.5	6.0	23
	Varicosities ..	2.8	5.4	20
	Genito-urinary ..	5.2	1.1	12
	Hernias	5.8	0.4	11
	Skin	1.7	1.4	7
	General debility ..	1.2	1.7	7
	Anaemia	1.2	1.4	3
	Endocrine	1.2	1.4	3
Teeth	Own teeth adequate ..	6.6	3.2	20
	Dentures	64.0	78.6	331
	Other	29.4	18.2	103
	(grossly defective)			
Other Symptoms	Impaired sight .. .	47.0	58.0	245
	Painful feet .. .	34.8	51.0	202
	Dyspnoea	38.4	43.2	188
	Giddiness	33.3	42.5	179
	Deafness	30.7	26.9	129
	Oedema	1.7	13.9	42
	Angina	4.1	3.9	18
	Tremor	4.1	2.1	13
Number of Symptoms recorded per Person	0	19.1	12.1	67
	1	22.7	21.0	98
	2	23.2	21.8	102
	3	19.2	20.0	89
	4	10.4	13.1	55
	5	4.7	8.1	31
	6	0.7	3.9	12

* Arranged in order of frequency, allowing only one defect per person

Arranged in this way there were only three noteworthy differences between males and females. On the one hand disturbances of locomotion (arthritis, rheumatism, etc.) were three to four times as important among the women as among the men, and on the other, hernias were ten times and genito-urinary troubles three times as important among the men. "Nil defects" headed both the lists, and if the three exceptions already mentioned are excluded the rank order of all but one of the remaining groups was the same for both sexes. The single deviation is due to the fact that disturbances of personality take sixth place in the female list and tenth place in the male list.

The women appeared more frequently in the list of symptoms than the men, averaging 2.41 symptoms per person as against 1.95 for the men. Swelling of the legs was not a frequent complaint but was nearly

six times as common among females as males. Women also suffered from painful feet and giddiness to a greater degree, but tremor (also rare) was found more often among men.

When the eight symptoms were studied in relation to one another, certain characteristic combinations were revealed. Thus, impaired sight tended to go hand in hand with dyspnoea and deafness. Giddiness was more frequently associated with dyspnoea, painful feet, impaired vision, oedema, and angina than would be expected if there had been nothing but chance association; dyspnoea also had a significant association with oedema and angina; in spite of their infrequent appearance, oedema and tremor overlapped.

PATHOLOGICAL CONDITIONS OCCURRING FOR THE FIRST TIME OR PERSISTING AFTER AGE 60.— Nearly 150 of the pathological conditions listed in the International Classification of Diseases and Injuries (W.H.O., 1949) were represented in the sample. Not including recurrences, and naming only conditions which occurred for the first time after the age of 60 or had left residual signs, the men shared 330 conditions and the women 612 (Table VII overleaf). Just over 12 per cent. of the men and 8.5 per cent. of the women said that they had remained well during this period, and in 62 cases four or more conditions were superimposed. Though the women were rather more often affected, the average number of conditions per person was not significantly different for the two sexes.

Foot defects (202) headed the list, and these, combined with other diseases of bones and joints (115), were about three times as common as diseases of the heart and arteries (115) or acute and chronic diseases of the lungs (93). It is likely that an exhaustive examination would have yielded some evidence of arterio-sclerosis or venous incompetence in every single person, but over two-thirds of the group had escaped manifest disease of the heart and blood vessels. Major injuries (46) and diseases of the skin (47), eye (43), intestines (41), and genito-urinary tract (44) were almost equally common, but after these there were only two disease groups, namely personality defects (32) and hernias (39), with more than a dozen examples.

There was a general tendency for those over 80 years old to have a higher incidence of pathological conditions than the younger persons, but except for vascular and pulmonary diseases the accretions were not at all numerous. In spite of more years of exposure to risk major injuries were actually less common among the men and women who had survived to the oldest age group than in those who

were still below the age of 80. This could equally well be due to the fact that accident proneness and longevity are incompatible, or to the fact that the older members of the Survey group failed to report every major injury which had happened in the last 20 or 30 years.

Several of the more common pathological conditions were equally distributed between the men and the women—notably respiratory infections, strokes and other conditions due to hardening of the arteries, eye diseases, and skin lesions. Hernia was distinctly a disease of men as, to a lesser extent, was peptic ulcer. There were, however, many more conditions which showed a female bias (*e.g.*, injuries, arthritis, herpes, cancer, personality defects, appendicitis, gall stones, and the less common forms of heart disease).

TABLE VII
DISEASES OCCURRING OR PERSISTING AFTER
THE AGE OF 60

Diagnostic Group	Male				Female			
	60s	70s	80s	All Ages (per cent.)	60s	70s	80s	All Ages (per cent.)
All Fractures and Major Injuries ..	5	5	3	7.6	6	18	11	12.4
Hernias ..	10	19	6	20.3	1	3	—	1.4
Foot Defects ..	24	27	9	34.9	46	69	27	50.4
Arthritis, Fibrositis, etc.	6	21	8	20.3	22	39	19	28.4
Herpes Zoster ..	1	1	—	1.2	1	7	2	3.5
Other Skin Diseases	8	6	3	9.9	11	12	7	10.6
Cancer (all sites) ..	—	2	—	1.2	4	2	1	2.5
Diabetes ..	—	2	—	1.2	—	1	—	0.4
Personality Defects	1	4	1	3.5	9	10	6	8.9
Vascular Accidents of C.N.S. ..	1	4	1	3.5	1	4	6	3.9
Other Arteriosclerosis ..	10	14	3	15.7	9	29	14	14.9
Other Cardiac ..	—	4	—	2.3	5	7	3	5.3
Varicosities ..	1	5	2	4.7	10	16	4	10.6
Acute Respiratory ..	4	10	5	11.0	10	19	4	11.7
Chronic Respiratory	2	14	3	11.0	6	16	5	9.6
Gastric and Duodenal ..	8	6	1	8.7	3	9	2	5.0
Other Intestinal ..	—	3	1	1.7	5	8	5	6.4
Genital ..	3	8	4	8.1	2	9	1	4.3
Urinary ..	1	5	2	4.7	2	5	2	3.2
Blood ..	—	1	2	1.7	—	2	—	0.7
Cataract ..	2	3	5	5.8	4	7	4	5.3
Other Eye Diseases ..	2	3	3	4.7	3	10	6	6.7
Severe Deafness ..	3	4	6	7.6	3	7	11	7.4
No Illnesses or Accidents ..	8	12	1	12.2	11	11	2	8.5
No. of Persons ..	53	94	25	172	88	146	48	282

All cases of moderate deafness and faulty sight due to hypermetropia have been omitted, also five cases of obesity and three of goitre.

Except in the case of injuries, repeated episodes of the same condition are not included.

ARRANGEMENTS FOR MEDICAL SUPERVISION.—During the 12 months which preceded each interview, 228 of the old persons had sought medical advice (Table VIII). A further six had not consulted a doctor but had experienced an illness which kept them in bed for more than 10 days, and ten who had had no reason to consult their doctor had been treated by a chiropodist.

The total number attending chiropodists was five men and 28 women. Only 41 had been referred to hospitals; of these 26 had been admitted and five were on the waiting list.

TABLE VIII
ARRANGEMENTS FOR MEDICAL SUPERVISION DURING
12 MONTHS PRECEDING INTERVIEW

Type of Medical Attention		Males	Females	Both Sexes (per cent.)
Hospital†	Out-patient only ..	3	7	2.2
	Awaiting admission ..	1	4	1.1
	In-patient ..	11	15	5.7
General Practitioner	Acute bed illness*	24	52	16.8
	Other home supervision ..	7	31	8.4
	Attended surgery**	51	75	2.8
No Medical Supervision	Acute bed illness ..	3	3	1.3
	No acute illness ..	87	123	46.3
Nursing Arrangements	Acute bed illness	Relative or friend (unpaid)		
		17	30	10.0
		7	22	6.4
	Other home supervision	District nurse, etc. Managed alone		
		3	3	1.3
		3	18	4.6
Chiropody	Only ..	Relative or friend (unpaid)		
		3	11	3.1
		1	2	0.7
Chiropody	With other supervision ..	1	9	2.2
		4	19	5.1

† The method of sampling automatically excluded old persons who had been admitted to hospital for an indefinite period (see page 139).

* Defined as an acute illness necessitating more than 10 consecutive days in bed.

** Surgery visits were 40 per cent. less frequent in rural areas than in town.

Acute bed illnesses (not counting episodes which lasted less than 10 days) were equally distributed between the two sexes, as were also visits to the doctor's surgery. More prolonged home supervision by a general practitioner—usually for incurable conditions—was, however, three times more often required for the women than for the men, and visits to the surgery were over twice as frequent among town dwellers as among villagers.

Regarding the nursing arrangements, it was interesting to observe that nearly two-thirds of the services were provided (usually free of charge and often at the cost of giving up paid work) by relatives or friends. In this respect there was no difference

between the men and the women or between the towns and the rural areas. Most of the trained nurses were provided by the Local Authority, but in a few cases a private nurse had been engaged. In eight cases (all women) there was clear evidence that the prolonged ill health of the old person was putting such a heavy load on available resources that these were about to break down under the strain.

If the Survey findings are representative, about 20,000 old persons in Dorset regularly consult their general practitioners and over 3,000 are treated in hospital every year. District Nurses are called upon to attend between 2,000 and 3,000 cases of acute illness and a further 1,000 persons with chronic complaints.

Meanwhile relatives and friends are shouldering the day-to-day responsibilities of nearly 4,000 cases of acute illness and 2,000 cases of chronic illness among old persons. To check these estimates the visiting lists of District Nurses practising in Poole were inspected. During the years 1950 and 1951 these nurses paid 2,044 "first visits". Since approximately one-third of the old people in Dorset live in Poole these lists correspond to approximately 3,400 visits per year for the County as a whole—a figure very close to the one based on the survey estimates.

DISCUSSION

With monotonous regularity surveys demonstrate that old people are less well placed and less healthy than their younger brothers and sisters and that more women survive to old age than men. Yet we are still far from knowing the measure of a problem which is steadily increasing in size and importance. One reason is that, in spite of all that has been written on the subject of old age, there are only three recorded surveys in the British Isles where the data were collected by a medical practitioner paying home visits to a representative sample of the population (Walker, 1947; Sheldon, 1948; Adams and Cheeseman, 1951). To quote the words of Sheldon, such an approach "does not make for ease of working: all sorts of inaccessible personalities may be encountered, and it is very time-consuming, but the degree of self selection imposed by the population on itself in regard to its approach to doctors inevitably gives anything other than a random sample a considerable bias".

The Poor Law method of dealing with people who had outlived their strength and had neither relatives nor money to supply the deficiency was to offer them accommodation in a workhouse infirmary. Nowadays this policy is frowned upon. Yet we are still nervously aware that it is easier to say that old

infirm people should not be immured in institutions than to make it possible for them to live at home. Since it is unlikely that an ideal scheme will be devised until we know more about the natural history of old age, it is reasonable to suggest that any record of the situation as it exists to-day is relevant.

In the present investigation we have tried to size up the situation in Dorset by identifying a sample of old people who are still fending for themselves and by recording their home background and medical condition. Our attempts to judge the latter have been focussed on three things: prognostic indications, principal disabilities, and all major illnesses occurring or persisting after the age of 60.

To obtain significant correlations between the two types of data, many more than 454 old persons should have been interviewed, but even a bare statement of the findings under the several headings has yielded facts of general and local interest. It has, for instance, been shown that, although a high proportion of old persons living in Dorset are unsuitably housed, their share of property owned by the local authority is lamentably small. No doubt this is due to the fact that here, as elsewhere, a high ratio of persons per room is a more effective criterion for rehousing than a low standard of repairs and amenities (Weir, 1953). It is, however, a reminder that housing priorities should be differently graded for old and young households if we are to avoid on the one hand, unnecessary inflation of the demand for old people's hostels and, on the other, the freezing of property which is more suited to the needs of youth than age.

Other findings of sociological interest are the number of households with no-one under the age of 65, the number of men who would like to go on working after 65 years of age, and the relatively large number of women (widows and spinsters) who live alone. On the medical side it has been noted that, in spite of there being more manifestly unfit women than men, the prospect of remaining in good health for some time was almost equally good for the two sexes and applied to nearly half the group.

Many more supporting facts would be required before we could say that the public facilities for old people in Dorset are the best that the county can afford, or that the findings in this county are typical of the population at large. But perhaps enough has been said to show that among the most important facts required to make these assessments are those which can only be supplied by surveys focussed on randomly selected groups of old people in which experienced physicians interview the subjects in their own homes.

SUMMARY

A survey of the health and living conditions of old people living in private houses in Dorset has shown that on nearly all counts the welfare needs of women are numerically greater than those of men, and that the housing problems in rural areas are of a totally different order from those in the towns.

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