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SOLIDARITY WITH THE ELDERLY AND THE ALLOCATION OF RESOURCES

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Introduction

One of the cornerstones of European health care systems is the principle of solidarity. The care of the elderly, including health care and social care, is in many respects based on this principle: the young contribute to the costs of care for the old who have a greater risk of disease and handicaps. But the increasing demand for care by the elderly—resulting from epidemiological changes as well as various social processes—is putting the solidarity between the young and the old under strain. Particularly the medicalization of old age, which is draining away resources from long-term care, is an important threat to the preparedness of the younger generations to take care of the needs of older persons. One of the theses of this chapter is that the process of medicalization should be stopped, not by an age limit (as advocated by Daniel Callahan and others), but by introducing a two-tier system, based on the principle of humanitarian solidarity.

Longer Life, Worsening Health

Since the beginning of this century, the average life expectancy has risen significantly in the industrialized world. In the early 1900s, it was approximately fifty years. At this moment the average life expectancy is seventy-six years for both the United States and for the member states of the European Community. Life-expectancy is higher for women than for men: seventy-three for men and seventy-nine years for women in the EC.

The increase of the average life-expectancy is expected to continue: in the year 2025 it will be eighty years, seventy-seven years for men and eighty-two years for women.[1]

The increase of average life-expectancy however, cannot be called a success in all respects.[2] While individuals can enjoy themselves in a longer life, they are suffering from chronic, debilitating diseases that are typical for the later stages of life. The higher one's age, the greater the risk of being handicapped by chronic diseases, for example diseases of the sensory organs, as well as neurological and cardiovascular diseases. In fact, the healthy life expectancy, that is the period of life that is free from diseases and handicaps, has remained the same, but the average life-expectancy has risen. By consequence, we are living in bad health for an increasing part of our lives.[3]

Noting the difference between healthy life expectancy and average life expectancy, we can understand better the increasing demand for long-term care. This is particularly true for the age group of eighty years and above, the fastest growing age group in the industrialized world: from 16 million in the EC in 1980 to 29 million in 2010.[4] This age group is particularly tortured physically and psychologically by dementia, depression, osteoporosis (including the breaking of hips and arms), and cerebral-vascular accidents. Moreover, the eighty-year-olds have an increasing chance for lesser, but not less debilitating handicaps, like visual and acoustic impairments, genito-urinary

diseases, and psychiatric disorders. They are also afflicted by loneliness, social abandonment, and poor nutrition.[5] As a result of these handicaps, the eighty-year-olds are, more than any other age group, dependent on professional care, particularly home care, nursing home care, and hospital care. The rapid growth of this age group will result in a sharp rise in the demand for care in the near future.

Social Processes and the Demand for Care

In view of demographic projections and epidemiological developments, how large will be the increase in the demand for care by the elderly? There is no easy answer to this question: the demand for care is determined not only by the demographic process only, but by other social processes as well.[6] The most important of these processes are medicalization, decreasing availability of informal care, and the values and norms with respect to the elderly.

Medicalization can be defined as the process by which human existence is increasingly understood in terms of health and disease,[7] and it is characterized by an increasing utilization of medical services. This will very likely continue to increase in the coming decades because of the continuous growth of medical knowledge on the one hand and the increasing public awareness of the possibilities of this technology on the other hand.[8] Patients and doctors are moved by a "quest for certainty," which is very costly, as more and more diagnostics have to be performed to rule out disease or to confirm a diagnosis.

The availability of informal care—care given by family members or neighbors—also affects the level of demand for medical care. As a result of the ongoing individualization of society and the breakdown of traditional forms of solidarity, this kind of informal care is becoming more scarce. Children are moving away from their parents to other cities, having their own families or are getting divorced. They have a more individualistic lifestyle with norms and values that are different than those of their elder parents. Moreover, an increasing part of the population is living in arrangements other than the traditional family. The willingness to provide informal care is also lessened by a decline in the number of children and the emancipation of women. Moreover, at the same time that parents are becoming needy, their children are already at an age at which they likely will have problems with their own health. Instead of burdening children or neighbors, the elderly are more inclined to ask for professional help.

The values and norms with respect to the elderly are also playing an important role in the demand for care. Though the elderly are very often willing to work longer and to make themselves useful for society, they are forced to leave the workforce at the age of sixty-five or even earlier. Because employment opportunities will not likely increase in the future (due also to the increasing participation of women), the pensioning age will probably not be changed in the coming decades. In general, the elderly are expected to disengage from

society, making room for younger generations.[8]

It can be expected that the difference between the aspirations of the elderly on the one hand and the lack of willingness of society to respond to these aspirations will result in lower responsibility for health and a decline in subjective health status. These processes will give rise to increasing visits to general practitioners and to an increasing utilization of other medical services.[8]

Scarcity of care resources

For the Netherlands, it is expected that, as a result of the demographic process only (that is the increase of the number of aged and very aged persons combined with their mortality rates and their objective and subjective health status), the demand for care will increase at the rate of 1 percent each year.[9] This figure can be lower or higher, depending on the degree of influence of social processes mentioned above.

Increasing medicalization and individualization and the worsening of the position of the elderly in society will result in a faster increase of the demand for care. For the Netherlands, the figure will then be more than the one percent, which is predicted for the demographic shift alone. If the medicalization decreases and the solidarity between the generations increases, then the demand for care will decrease and will be less than one percent. It is to be expected, however, that the former, not the latter, scenario will take place. In the Netherlands, and probably also in other Western European countries, we will have

figure is just enough to account for the increasing demand by the demographic shift only.[11] But as we have seen above, the annual demand for care will probably much higher. Consequently, waiting lists for many services, particularly those for the elderly. In the Netherlands there are large waiting lists for nursing homes, homes for the elderly, home care, and cataract surgery.

Solidarity with the Elderly

Care for the elderly in most European countries is based on the principle of solidarity. Solidarity means that the strong—for example persons with high incomes or low health risks—contribute toward the costs of the care for the weak—that is persons with lower incomes or greater risks on diseases and handicaps. The principle of solidarity assumes the conscious and voluntary choice for unity with certain people, groups, or populations.[12] This choice was once limited to members of an individual's immediate group, for instance family, village, or social class. This "group solidarity" played an important role in the history of health care insurance. Workers, employees or civil servants united voluntarily in sickness funds to safeguard themselves against the financial risks of disease and physical or mental handicap. Solidarity was not limited to health insurance, but was a basic principle in other social security schemes as well, like pensioning schemes, unemployment insurance, and disability insurance and workers' compensation.

From the moment society is changed into a loose community of individuals or small groups protected by collective arrangements

of the state, group solidarity is replaced by a solidarity of interests. People are now sharing certain risks together with individuals belonging to other social categories out of clear self-interest. Such solidarity is not a conscious choice for unity with people in the same group, but a compulsory measure enforced by the state. Nowadays, solidarity means the obligation to share the financial risks of illness and handicap with other people, not necessarily of one's own social group. In exchange for meeting the obligation to pay a premium, people have access to a broad package of health care services.

Solidarity of interests is based on the principle of reciprocity: people share risks that are common to each other. For uncommon risks or risks that are the result of irresponsible behavior, there is only a narrow base. In an era of limited resources, general solidarity across groups is giving way to a tendency to blame groups of persons who are limiting the access to care services by their irresponsible behavior or excessive health claims. Public attention is focused on persons who put their health at risk by unhealthy life-styles or dangerous activities, particularly people who smoke, drink, use drugs, engage in unprotected sex, or injure themselves by playing sports. According to this view, these persons ought to be limited in their access to health care services because of their lack of responsible behavior. But the reason why these groups of persons are blamed or discriminated is often arbitrary; there are many activities that are dangerous or have health risks.[13] Blaming

some groups for the scarcity of resources is a kind of scapegoating which has often to do with prejudice and moralism.

It is not unlikely that the elderly will be victimized in the same way. Historically, attitudes towards the elderly have never been positive and will inevitably become more negative in times of scarce resources. Because of their increasing demand for care and their dependency on others, the elderly are seen as a more and more of a burden for society. They occupy an increasing number of beds within the hospitals, which in some cases results in waiting lists for younger patients. Premiums for health care insurance are rising to pay the increasing costs of the care for the elderly. The scarcity of institutional care and home care is putting pressure on families and neighbors to take care of their elderly family members.

For their part, the elderly react with feelings of powerlessness and superfluity. This is particularly true in the Central European countries, where the respect for the elderly is already low and will deteriorate further as they impose more burdens for society and their families. The same process is also true for Western European countries—for example the United Kingdom, where the social status of the elderly is rapidly declining, partly because of their rising demand for care. The growing phenomenon of elderly abuse in nearly all European countries is writing on the wall.[14] Besides, the elderly have the idea that they are discriminated against, covertly or even overtly (as for example happens in the British National Health

System). Organizations of Dutch elderly point out, for example, that the majority of waiting lists are for services that are important for the elderly, such as nursing home care, home care, cataract surgery, and hip replacements.

It would not be fair to blame the elderly for the scarcity of resources (which in some countries seems to be the case). The demographic shift is only partly responsible for the growing demand for health care. Much more important is the impact of medicalization and individualization and the decreasing of the solidarity between the generations. The increase of the number and proportion of the elderly is not the main cause of the growing demand for care, but the way the elderly are treated by our society in general and the medical system in particular.[15] The rise in demand for care has much to do with high and exaggerated expectations of medicine's potential to enlarge the quality and quantity of our lives. The alleged impact of demography on the demand for care is thus grossly exaggerated: focusing on the demographic process looks very much like creating a myth, which hinders an insight into the real causes of the scarcity of resources. The elderly are an easy target who by their alleged excessive claim on health care are said to be limiting the access to care for other age groups.

Medicalization of old age

Without blaming the victim, we must still rethink our solidarity across generations. The increasing demand for care by the elderly is putting heavy strains on the social resources for

health care and on the willingness of younger generations to take care of their dependent parents. Are the elderly entitled to all of our resources for health care or may we set some limits on what care they will receive?

This problem emerges particularly in acute care medicine. There is a tendency to treat older and older patients with sophisticated medical technologies.[16] The number of people over eighty years or even ninety years of age who are getting open heart surgery, organ transplantation, or renal dialysis is increasing rapidly. These medical treatments do not simply prolong organic life, but are really beneficial in restoring health and quality of life. Octogenarians, for example, are benefiting very well from open heart surgery. A leading Dutch cardiologist said recently that "age is hardly an indication against cardiac surgery for patients who are in a good condition."[17] In fact, the real "problem" is that a growing number of elderly is in a very good condition and eligible for nearly all kinds of medical interventions, even in their eighties or nineties.

This process of medicalization of old age, which is fuelled by health economic processes, will put increasing strains on the intergenerational solidarity in two ways. First, it will hinder the access of younger patients to acute care services. This is already apparent in the field of heart transplantation, where there is a structural scarcity of donor organs—that is, scarcity that is not the result of financial resources (and thus that

could be removed by greater efficiency or more money), but of other social or physical causes. The same problem is coming up in intensive care units: though the elderly benefit from high technology procedures, they need more time to recover in the ICU. The "greying" of these units will result in limited access of younger persons who are in extreme need. For instance, in December 1990 a young child died in Amsterdam because there was no room in the ICUs of the hospitals of the neighboring city of Haarlem, which were for a large part occupied by elderly patients.

A second problem is that the increased use of acute care services will drain away resources from long-term care. Consequently, there will be a growing demand for informal care by family members or neighbors. Though many of them, particularly daughters, are willing to supply this care, there are limits to their physical and emotional resources. While most adult children want to express solidarity with own their parents, they do have their own life plans and their own children to care for.

Limits to the Elderly?

One of the most hotly debated proposals in the ethics of resource allocation is the notion of setting an age limit for acute care services. Well known (and controversial) are the ideas of Daniel Callahan, who opposes the medicalization of old age and believes that, within the next twenty to thirty years, it may be necessary to set an age limit on the use of expensive, life-prolonging technology.[18] He proposes instead that the

emphasis be given to providing decent economic support and long-term and home care. There should be, that is, a shift from curing to caring beyond a certain age (he suggests the late seventies or early eighties as the time to draw the line), with the goal of insuring a good balance of resources between young and old and a limit to efforts to endlessly push back the frontiers of acute care medicine for the old.

This proposal for the allocation of resources for the elderly has been strongly criticized as a kind of "ageist" discrimination.[19] Gerontologists and liberal ethicists particularly have argued that every age has its own aims and that nobody can determine for another whether his life is completed or his "natural life span" has been reached. There is no reason, they argue, to suppose that an old person values his life less than a younger one. When one considers only years of life instead of life only, one shows no respect for the unique value of the human person, which is the moral basis for our society.

Other authors have doubts about the financial savings of Callahan's proposal. The increase of health care expenditures that come with age are not due to life-extending treatments, but largely to visits to general practitioners and hospitalization.[20] Regarding hospital care for the elderly, the majority of the admissions for the elderly is for life-enhancing care, that is, care that tries to improve those physical functions which are needed for normal daily activities.[21] At the end of life, the largest share of the costs of care is taken by the care in

nursing homes, home care, and other kinds of long-term care. The costs of intensive, life-extending hospital care are much lower, compared to the costs of nursing and supporting.[22] For each person, the majority of the costs of care are made at the end of life, particularly in the last twelve months of life. However, these are mainly expensive labor costs for nursing and caring, with only a small portion of costs attributed to aggressive, intensive treatment for patients who are moribund.[23] [24] [25]

Indeed, limiting acute, life-extending care to the elderly <u>at this moment</u> will not solve the allocation problem, as there will be no (direct) financial gain. However, the increasing medicalization of old age will in the future result in an increasing utilization of curative services by elderly persons. It is therefore to be expected that limits to acute cure for the elderly will in the coming decades make more of a substantial contribution to the allocation of resources for the elderly than in the present situation. Still, it must be doubted that age limits will solve the allocation problem, now or in the near future. To be sure, there are situations on a clinical level in which treatment possibilities are limited and a choice must be made between a person who had a "fair share of life" and one who has not. In such situations it would not be unreasonable to choose for the latter. However, turning such decisions into an official policy might reinforce a negative view of old age and the elderly in our society. In fact, this would result in a lower responsibility by the elderly for their health and a lower

subjective health status. A policy of age rationing will then ultimately result in more visits by the elderly to physicians, particularly general practitioners, and thus contribute to an *increase* in the demand for care.

Apart from these concerns, there are serious doubts as to whether an age-criterion will ever be accepted in modern society. Part of the process of individualization, referred to above, is the disappearance of traditional social relationships. Traditional values and structures of authority are replaced by relationships based on negotiation and equal respect. This process can be noted in the clinic (doctor-patient relationship),[26] as well as in other social areas like the family, the school and the workplace. Two important features of negotiation process are that it presupposes no fixed rules or shared notions of the good and that age or generation are loosing ground as criteria for social arrangements and relationships.[27] Such an "age-irrelevant" society, as Bernice Neugarten styled it, is a perfect breeding ground for liberal ideologies which deny any special status to the elderly other than that they are equal to any other person in society.

Access to care

When there is a scarcity of resources, the better off will have more opportunities to buy a better quality of care or to jump waiting lists for scarce medical treatments. National governments, unwilling to make difficult choices in health care, are trying to increase personal financial responsibility for

health care services, for instance by copayments, compulsory deductibles, or additional private insurance. Most of these payments are for long-term care services, none of them for acute care (with an exception, in some countries, for medical drugs). This shift from collective responsibility toward private responsibility fits very well with the retreat of the welfare state, the introduction of market forces, and a greater emphasis on freedom in the health care system. However, more freedom will inevitably result in greater inequalities in access to care. Particularly the elderly, many with low incomes and pensions, will be affected by such policies.

The introduction of such a two-tier system in health care—that is, a system with a universally accessible basic tier financed by society, and there above a privately financed tier—is often criticized as a danger to solidarity and equality, which are basic values for European health care systems. However, provided that society is supplying an adequate package of health care services, to which all persons have equal access (unhindered by co-payments or other financial obstacles), persons who buy their own services exceeding this package do not offend any ethical principle in doing so.[28]

An important question is, of course, What is an adequate package of care services, particularly for the elderly? The answer to this question depends on society's values and expectations of society in regard to health care. One value, which in many countries is strongly adhered to, is "humanitarian

solidarity." This kind of solidarity, which is based on the dignity of the human person, wants to protect those human persons whose existence is threatened by circumstances beyond their own control, particularly natural causes or unfair social structures.[29] Humanitarian solidarity should be the starting point for the defining of necessary care, as was advocated by the Committee Choices in Health Care in the Netherlands. Care services for persons unable to care for themselves because of psychological handicaps, for example, by Alzheimer disease, psychiatric disorders, or mental retardation, should have priority in the basic package. The remaining content (and extent) of the basic package should be given over (in rank order) to other kinds of long-term care (for example home care), acute care services, and for less important health care services. Defined in this way, the basic package should be equally accessible to all, without financial constraints like co-payments or obligatory risks. Persons wanting acute care services not supplied by the basic package should pay those services out of their own pocket or insure themselves privately for those services.

Primacy of care

A two-tier system based on the principle of humanitarian solidarity puts care, and not cure, at the center of its efforts to provide an adequate level of health care. While cure has a permanent tendency to vanquish the barriers of illness and death, care has much more modest aspirations and is more self-containing.[30] Moreover, the emphasis on care can preserve the

respect for the human person that might be endangered by the need to set limits and the exclusion of acute services from the basic package, for example by a two-tier system. [31] By securing access to long term care services and limiting access to some acute care services, a two-tier system based on the principle of humanitarian solidarity might limit the medicalization of old age, which is the most important threat to the solidarity between the young and the old.

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21. For example, the most often performed operations for the elderly in Dutch hospitals are cataract surgery, prostate surgery, hip replacement, and treatment for inguinal ruptures. The first life-extending treatment—coronary by-pass grafting—is on line number fourteen. On the basis of this list, the chairman of the Dutch Health Council, Mrs. Borst-Eilers, has calculated that limiting life-extending care to people over seventy-five would save only 100 or 200 million guilders, that is 0.5 percent of the Dutch health care budget of 40 billion guilders. See E. Borst-Eilers, "Leeftijd als criterium," in *Grenzen aan de zorg: Zorgen aan de grens*, ed. J.K.M. Gevers and H.J. Hubben (Alphen aan de Rijn: Tjeenk Willink, 1990), pp. 66-72.

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31. "It is in caring that we can respect the claims and calls of individuality, that we can most show our solidarity with each other." (Callahan, *What Kind of Life?*, p. 149.)