Dying, not old age, to blame for costs of health care

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In July, 1997, a cruise liner ran aground off the Norwegian coast, and the coastguard had to take the passengers off. News reporting of this incident emphasised the age of those on board; most were well over 70. This incident and the reporting of it may merely underline the importance of the elderly for the holiday market these days yet the picture of old people at the helm of a life-raft in the Arctic prompted in us another reaction. How different this was from the way the elderly appear in many other news items. Whenever health-care costs are an issue the finger is pointed at them, the assumption being that ageing is a process of ever more illness and disability so that old age is to blame for the high costs of medical care.

We want to challenge this generally held view, arguing that the costs of health care are related to the process of dying. The secular trend of an ageing population in developed countries may seem to attribute health-care costs to old age—the trend itself implies dying at a greater age—but ageing itself is not the main mechanism driving rising health-care costs.

The definition of old age is ambiguous. Traditionally, the official age of retirement (65 in many countries) has been used to identify “the elderly”. A more realistic, though equally controversial cut-off is 75, and that is used in this essay.

The most common chronic diseases encountered in primary medical care 1 (eg, chronic obstructive pulmonary disease, non-insulin-dependent diabetes mellitus, and heart failure) feature particularly in the later decades of life and affect life expectancy. An even more significant marker of the complexity of ill-health, and of consequent costs, is comorbidity; a high proportion of the over-75s are under treatment for two or more chronic diseases.2 The relation between age, morbidity, and health-care costs is not straightforward. Demographic change is just one factor; general inflation contributes too as do developments in medical technology.3 If we take a closer look at the most common illnesses, according to age, encountered in primary care (tables 1 and 2), two observations stand out. The everyday ailments (eg, colds, muscle pain, psychosomatic complaints, and low back pain) that prevail in younger populations continue into old age; and the chronic diseases, which severely impact on life expectancy and quality of life and are so characteristic of the over-75s, already make their mark in the earlier decades. Of those chronic conditions, only cataract, heart failure, and stroke are unusual at age 45–64. A similar pattern is seen for comorbidity. That starts to become an issue from age 60–65 but many of those aged 75 or more remain free of any chronic morbidity.4 Indeed demands for medical care and self-reported health status in the population have remained stable over time despite increasing life expectancy, and health-care costs for acute medical care bunch up at the end of life 5 but there is little information available on the exact distribution of expenditure. Insurance data for the Netherlands (E de Koning, personal communication) show that in those aged 65 or over the medically costs in the last 18 months of life are roughly three times (12 000 vs 4200 Dfl per year) those for earlier years. In other words about 25% of a lifetime’s expenditure on the health of an individual is spent during the last couple of years of life. Since Dutch health insurance does not include elements of health care covered by social security (eg, nursing homes) the true proportion may be nearer 30% or even 40%.

The last period of life (any life, at any age) is usually marked, by definition, by illness that cannot be cured or controlled despite strenuous medical efforts. Add to those efforts the need to alleviate pain and distress and to promote comfort, and costs can be expected to accumulate at the end of life. Since reaching old age, as treatment in the oldest age groups (80+) were lower than for the younger elderly in one US study.6

Over the years medicine has had more to offer in terms of both diagnosis and, to a lesser degree, treatment. In medicine the “new” tends to be more costly than the established and also more complex to manage, and this combination is often singled out as an important source of increased health-care expenditure.5 6 However, in large part the use of medical facilities, and thus health expenditure, is provider driven. The costs of medical care are a cruise liner ran aground off the Norwegian coast, and the coastguard had to take the passengers off. News reporting of this incident emphasised the age of those on board; most were well over 70. This incident and the reporting of it may merely underline the importance of the elderly for the holiday market these days yet the picture of old people at the helm of a life-raft in the Arctic prompted in us another reaction. How different this was from the way the elderly appear in many other news items. Whenever health-care costs are an issue the finger is pointed at them, the assumption being that ageing is a process of ever more illness and disability so that old age is to blame for the high costs of medical care.

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we have defined it, is now the norm in many countries, those for whom those terminal expenditures mount up will be over 75 but those costs need to be properly attributed—to the terminal phase of life, not to old age as such.

Ageing is, in our view, a powerful marker of the health of the population, and it should not be stigmatised as a waste, a burden on society. Our hypothesis is that it is dying rather than old age that implies high costs. At the same time we must not forget that good palliative care is something that everyone, whether they die earlier or later in life, is entitled to.

Elderly people in a lifeboat in the Arctic may not be a target to aim for but, as a consequence of ageing, it is a better image than that of older people surreptitiously consuming more than their share of national budgets for health.

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Myths of ageing

Graham P Mulley

"Old age" is synonymous with frailty, decrepitude, and senility. As people age, they inevitably develop degenerative disease for which little can be done. Very old people can no longer cope at home, and now that families no longer care for their elders most go into institutional care. The medical profession is to blame for the burgeoning numbers of aged people.

These are some of the myths of ageing which are reflected in apocalyptic terminology (rising tides, demographic time-bombs, grey hordes), negative stereotypes, and suboptimal care. Myths (from the Greek muthos, a fable or legend) are invented stories, imaginary ideas, fictions. How have the myths of ageing affected the way we think and talk about older people and our attitudes and behaviour towards them?

In the Graeco-Roman era average life expectancy in Europe was 20 years. By the year 1000 it had risen to about 30. By the mid-19th century, an American could expect to live for 39 years; by 1911 the figure was 46 and in 1930 it was 55. Over the past 100 years, the proportion of Britons over 65 has risen from 5% to 16%. Population prediction is not a precise science but, with artificially prolonging life by drugs, surgery, and medical technology. In 1919, 12% of deaths in Britain were in the first year of life (the current figure is less than 1%); 65% of people died before they were 65 (today 19%). The "greying of nations" is therefore largely the result of the great reduction in premature deaths. Lately, however, prolongation of life does seem to be related to medical intervention: in the USA, much of the improvement in life expectancy has been attributed to access to the Medicare and Medicaid services. In Britain, only 3% of men and 6-4% of women over 65 are in residential or nursing homes. The proportion of people in care rises steeply with age (but varies greatly between countries); even so, four-fifths of those over 85 live in their own homes. The older you are, the more likely it is that you will live alone. Two-thirds of people aged 65–74 are married compared with one in six of those over 85. Being alone does not mean being lonely; although 90% of the general population believe that loneliness is a problem in old age only one in ten older people feels lonely very often.

The myth of selfish relatives who fail to meet their responsibilities to older people is as unfortunate as it is mistaken. Most support is still given by families. Many caregivers are spouses; one-third of us can expect to become caregivers in retirement. The belief that relatives of ethnic elders can support almost any chronic disease in old age is questionable.

Forbidden phrases in geriatric medicine include "Just your age" and "What do you expect at your age?" If a condition were solely due to ageing, it would become progressively common with advanced age and be universal in very late life. It would be equally common in older people of different races and at different times. Some disorders do increase exponentially with age (eg, fracture of the proximal femur) but cataract may be one of the few conditions which everyone will develop if they live long enough. Age-related macular degeneration clinically affects only a minority of older people, and is