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The Health Care System and the Elderly

DEMOGRAPHICS

Currently 12.7% of the Canadian population is aged 65 and over. By 2026 the proportion will increase to 21.42%. The very elderly, those 85 and above, will increase by over a 100% during this period.[1] In 1991 Canadians over 65 years of age had a life expectancy of 18 years, 9 years of which were expected to be disability free, while the remaining nine were expected to include 3 years each of slight, moderate and severe disabilities.[2] The aging population is a global phenomenon, which is being termed the "silent revolution." Some developing countries are aging at a faster rate than developed countries. The oldest old are the fastest growing component of many national populations.

IMPACT

An aging population has major societal and ethical implications. Intergenerational tensions lead to "ageism," which has been defined as systematic and negative age discrimination. There is a stereotyping of the elderly as physically and mentally incompetent. Older workers face difficulties in the job market and also have to contend with compulsory retirement. In times of economic restraint, there is competition for scarce resources and a perceived "pension burden" associated with an aging population. Workplaces face increasing time lost through workers needing to care for elderly relatives. The marketplace is changing due to the greater need for health services and pharmaceuticals, while the increased number of elderly voters will have political consequences. The major issue is the impact on the health care system, since responding to the needs of this aging population is one of the most significant challenges facing our already challenged system.

HEALTH CARE

Aging is not a disease, and the majority of the elderly remain physically and mentally independent. Degenerative diseases, however, become more frequent among the elderly. Key diseases include neurological degenerative diseases such as Alzheimer's and other causes of dementia. It has been estimated that 1 in every 13 Canadians over the age of 65 is affected with Alzheimer's disease and related dementias. Between the ages of 75 and 84, the ratio is 1:9, and over the age of 85 the ratio is 1:3.[3] Cerebrovascular disease, coronary artery disease, congestive cardiac failure, cancer, and chronic obstructive lung disease all increase in the elderly. Osteoarthritis and osteoporosis are widespread and lead to decreased mobility. Many of these diseases coexist, compounding the resulting disabilities and causing the prescribing of many medications. This results in syndromes called the 'giants of geriatrics,'[4] including falls, cognitive impairment, urinary incontinence, problems related to multiple medications and adverse medical interventions. At particular risk are the "frail elderly." These are usually 75 years of age or more, with complex multiple health problems that result in dependency in the activities of daily living. Approximately 15% of the population over 65 fits into this category.

The major goal of services for the frail elderly is to offset the impact of these chronic diseases so as to maintain quality of life and independence. There is a major cost in managing this group since the cost of treating the 85 and over has been calculated at 15 times more than those under the age of 55.[5] The acute hospitals are the most costly sector of the health care system, and the 65 and over now have the highest rate of hospitalization, the longest length of stay

with the greatest risk of functional decline and nursing home placement.[6] In 1995 and 1996 two-thirds of all hospital inpatient beds in British Columbia were taken by patients over 65.[7]

The health care system currently is not responding to the needs of the frail elderly. In the United Kingdom, an inquiry into the care of older people in acute wards in general hospitals entitled, "Not Because They Are Old", found that problems existed with the older patients and relatives' dissatisfaction with care, numerous deficiencies in physical environments, clear evidence of staff shortages, and concerns about nutrition.[8] Problems were also identified with preserving dignity, interactions with staff, insufficient training, poor discharge planning, and lack of accessibility of services in the community. A recent study by Health Canada on unmet needs reported that an estimated 7% of Canadians, or about 1.5 million, had unmet health-care needs during the previous years. [9]

In Scotland serious concerns about the health care of older people has led to a report, "Adding Life to Years."[10] The report examines specific concerns such as ageism. It notes that there has been a failure over the last three or four decades to adapt the health care services to the gradual but very substantial increase in the number of older patients being treated. The international relevance of this report was noted in an editorial in the *British Medical Journal*.[11]

Acute Care

Acute hospitals are the most expensive part of the health care system, but they function more for needs of the providers than for those of their major clients, the frail elderly.[12] They may provide a "hostile environment"[13] that leads to functional decline in the frail elderly and "a cascade of dependency"[14] that results in approximately one third of older patients losing independent functioning in one or more activities of daily living. This decline is not related to acute illnesses but to the adverse effects of modern therapy and current hospital practices, which are designed for younger people but cause loss of function in the elderly.

Community Care

The provision and availability of community services vary from province to province. In Ontario they are provided through the brokerage of the Community Care Access Centres. Hospital restructuring and the decrease in acute beds have led to the earlier discharge of sicker patients, and Community Care Access Centres have had to focus their resources on meeting the needs of these patients returned to the community. To meet this need, they have severely cut back in maintaining services to the frail elderly which are essential to keeping them in the community. Thus the frail elderly are becoming increasingly dependent on their families and friends, or they have to turn to the private sector. The poor, of course, are unable to have recourse to this latter option.

Long-Term Care

In Ontario, the Ministry of Health and Long-Term Care has made the significant commitment of adding 20,000 more long-term care beds, but due to the restructuring of the hospital system, the long-term care facilities are being asked to manage a patient population previously looked after in chronic hospitals. This group has major and increasing care requirements due to the larger numbers of patients with dementing illnesses and resulting behavioral problems. The funding of these long-term care facilities will not be sufficient to provide the care necessary. Inevitably, there will be negative consequences and a return to the "warehousing of the elderly" of the 1960s.

Primary Care

The current system of family physicians providing care on a fee-for-service basis through short office visits is not well suited to meet the needs of the frail elderly with multiple conditions. Primary care reform, which would offer a more comprehensive multidisciplinary approach, is taking place, but at only a glacial pace.

Elder Abuse

This has been estimated to affect about 4% of the elderly and can take the form of physical, mental, financial, sexual abuse or neglect.[15] Many cases go unreported, and with an aging population, the problem will obviously increase, as will difficulties related to abuse in institutions.

End of Life Issues

Death is a natural stage in human life and in an aging society, the end-of-life care of seniors should become a national priority. The emphasis on end-of-life care has tended to focus on the needs of younger people with cancer or HIV/AIDS and not on the needs of seniors. There is an ongoing need to improve the care in the last stages of life by addressing issues of maintaining comfort, delivery of care, and clarifying ethical issues related to artificial nutrition and hydration, and resisting pressures for the legalization of physician-assisted suicide and euthanasia. The role of advance directives

as a means of recognizing the autonomy and wishes of the elderly is also an important issue. The Senate Committee report chaired by Senator Carstairs[16] and also the *Guide to End-of-Life Care of Seniors*,[17] have identified these concerns more fully.

EDUCATION AND ATTITUDES

Health care professionals are not well trained to manage the specific needs of the frail elderly. The focus is on diagnosis, investigation and curative treatments with a tendency to neglect the care and ongoing management necessary for maintaining autonomy and independence. Negative attitudes exist. The frail elderly are sometimes referred to as "bed blockers" or "placement problems." The term "gomer" has also been used. This is an acronym for "get out of my emergency room."[18] This typifies the approach of blaming the elderly for the problems rather than recognizing that the cause rests with the shortfalls of the health care system.

SOLUTIONS

The role of specialized geriatric services is a major factor in meeting this challenge. The fundamental premise of such services is that much of the disease, disability and dependence in old age is preventable, treatable or manageable in seniors with complex health problems and unique needs that present challenges for accurate diagnosis and assessment. Inaccurate diagnosis may result in inappropriate treatment, leading to further unnecessary loss of health and independence, premature placement and unnecessary long lengths of stay in acute care.[19] Such services should be made available to all Canadians, and community care must be enhanced. In Scotland, home support to the elderly is universally available. Technological innovations have been shown to be of value by Ontario's Saint Elizabeth Health Care.[20] Acute hospitals should become "elder friendly,"[21] and all health services made sensitive to the needs of seniors. In the United Kingdom, a National Framework for older people has been introduced with appropriate standards and accountability.[22] Canada would do well to follow this example.

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Notes

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ETHICAL ANALYSIS

Because ethics is connected to the fact that humans are relational beings, another way of framing the challenge of caring for the growing aging population is: "How are we to be in relationship with the elderly?" or "What will really benefit, improve and enrich their lives?"

Helene McCormack, a graduate student in Theology at Montréal's Concordia University, has undertaken a study on outreach ministry to the elderly. There are two noteworthy items in her preliminary report. First, McCormack identifies loss and loneliness as two major challenges facing older adults. Second, 81% of the respondents to her survey ranked "personal attributes" highest among the skills required for ministry to the elderly. These results remind us that humans are relational and that human dignity is linked to this fact.

When we speak of the normative ethics of care-giving to the elderly, human dignity is the core value. Ethical issues are influenced by values (or disvalues) associated with longevity and aging. "Value" refers to what we intend when we ask, "Is this good?" or "Is this right to do?" or "How do we care for the frail elderly?" Value involves reflection and deliberation and moves beyond immediate and spontaneous attractions or aversions.

An important dimension of value is what the Canadian thinker, Bernard Lonergan, calls *personal* values. These refer to the capacity within each of us to go beyond ourselves in affirming something about our world. Lonergan names them "personal" because one no longer judges or chooses at the level of individual or social need for survival or from a cultural worldview. Personal values enable us to transcend ourselves. We find something for which, or someone for whom, we desire to go beyond ourselves. In facing the challenge of the elderly, ethics propels us to ask very basic questions: "How and for what are we to live our lives?"

Drew Christiansen has suggested that two essential values in caring for the elderly are "liberty" and "welfare".[1] Christiansen links the notion of freedom with the worth of persons. There are two different senses of the word "freedom", one negative and the other positive. Freedom in the negative sense emphasizes becoming released from something that imprisons or limits us. Thus, for the older adult, to be free in this sense is not to have any of the usual limitations that aging brings. The second sense of freedom is positive. It means the positive act of *determining* who we are or what we become. Thus, freedom in this second sense means the freedom to decide about our lives. A person can be in prison or in a wheelchair or in an institution because of frailty and still be able to determine who he or she is and what he or she will become. This second sense of freedom is not dependent on escaping limitation. It is precisely this second sense of freedom that links liberty and human worth. The positive sense of freedom alerts us to human dignity. In the Judaeo-Christian tradition, human dignity is based on the belief that human beings are created in God's image. To be in God's image means we are not only creatures but also co-creators. We are free to *be* - to be in relation, to be moral, to be a person who *chooses*. Unlike the negative sense of freedom, this positive sense of freedom can grow despite other losses.

Another essential value that Christiansen names is "welfare" in the sense of responsibility to the other who is in need. Christiansen understands the concept of welfare as embracing a variety of different "goods" - financial support, provision of food, supervision of medication, etc. Welfare is expressed in many ways yet these ways cannot be written in a code because we are not dealing with a static reality but a relationship. The Jewish philosopher Emmanuel Levinas recognizes that responsibility is not something superimposed on us but is part of who we are. It is precisely because humans are relational beings that we *are* responsible to one another.

Bernard Lonergan has coined the term, "incarnate meaning." By this he means the way in which humans embody the values they choose. This notion corresponds concretely to our questions: "How are we to be in relationship with the elderly?" or "What will really benefit, improve and enrich the lives of the elderly?" Incarnate meaning is when "heart speaks to heart." It is the meaning of a life in and of itself. No question is perhaps as important as we age as this question: What is the meaning of my life? And nowhere do we find the answer as much as in relationship with another whose life is meaningful to us and to whom our life is meaningful. When we speak of an ethics of care for the elderly this is the foundation to any service we may provide - that I enter into relationship with this person - that this person calls me to transcend myself, and that this person makes me realize that there is something worth transcending myself for.

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