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Update

Can America Afford the Booming Elderly Population?

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It has been called the geriatric imperative, the next health-care crisis of America. Simple demographics show that the segment of our population most in need of health-care resources is the one that is growing the most rapidly. It has been estimated that of all the people in the history of the earth who have lived to 65 years of age, over half are alive today. For the first time in the history of this country, there are more persons older than 30 years than younger. In the United States, there are 32 million persons aged 65 and over, representing 12 percent of the U.S. population. By the year 2030 this number will rise to over 65 million or 22 percent of the population. In 1990, there were 50,000 persons aged 100 or over. In 10 short years, that number will double to 100,000. The fastest growing segment of the U.S. population is women over the age of 85, who are also the greatest users of health-care resources. The elderly consume 36 percent of expenditures for health care, 50 percent of the federal health-care budget, 33 percent of all hospital beds, and up to 30 percent of all prescription drug costs.

At a time when the American voting public rates escalating health-care cost as the number one problem facing this country, the provision of care to the elderly has become to some a challenge and to others the solution. The final solution.

The question is whether or not America can afford health care for this booming population. I would first like to review briefly what America thinks it can already afford. We can afford to build expensive hospitals which operate at disturbingly low occupancy rates. We can afford to develop and distribute and advertise over a dozen nonsteriodal anti-inflammatory drugs and a half-dozen ACE inhibitors, when two or three would more than suffice in each class. We can afford to spend over $3 billion in tobacco advertising while tobacco-related diseases account for 410,000 deaths each year and represent the greatest cause of preventable mortality and morbidity in this country. We can afford to allow 50,000 deaths each year from auto accidents, knowing that half of these are alcohol-related. We can afford hundreds of third-party payers, whose combined paperwork and overhead costs represent one-fifth of total health-care expenditures. We can afford a savings and loan scandal costing hundreds of billions of dollars and not even talk about it anymore. We can afford a nuclear arsenal powerful enough to kill every man, woman and child in the world several times over. And we can afford a multi-trillion-dollar national debt which is bankrupting today's citizens and will hold hostages tomorrow.

Indeed we are a rich country. I reject the argument that it is proven that we cannot yet afford to provide health care for the elderly of this country. Probably the fundamental question that needs to be answered is what we are about in this country. Although there are many voices ready to answer this question, I return to the Declaration of Independence. Our forefathers held

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"these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness." I suspect that the order is important. In our youth-oriented society, one would suspect that the pursuit of happiness has become the most important right, and any infringement of that right by having to provide for the life and autonomy of a frail, disenfranchised segment of our population may no longer be tolerated because it is expensive. At a time when the entire fabric of society is threatened by the disintegration of the family, when many children no longer know their fathers (much less their grandfathers), it seems ironic and teleologically absurd to ration health care on age criteria alone. After all, what is crucial is biological age, not chronological age. Our society desperately needs the continuity, heritage, and wisdom that only the old can provide.

Affordable health care can be achieved only by increasing resources or decreasing costs. Although I personally remain unconvinced that adequate resources are unavailable, I do believe there are measures that can be taken to control costs. Although my Republican soul is pessimistic about the federal government's ability to do anything right, some type of centralized payer system is essential if overhead is to be controlled and if we are serious in this country about providing access to basic health care for every citizen. Waste, duplication and inefficient utilization of expensive components of health care such as hospital buildings and state-of-the-art technology need to be reduced. Innovative and attractive approaches to preventive medicine need to be developed and funded, so that we don't continue to spend an inordinate amount of money in the last few months of life, which is often of poor quality. Resources now expended in such activities as the development of "me-too" drugs could be better channeled into studying the cost-effectiveness and utility of the myriad of treatment dilemmas that face the clinician today (e.g., should the elderly be treated pharmacologically for hypercholesterolemia?). Just because a treatment modality is available does not mean that it is either beneficial or cost-effective. We have no moral obligation to provide even inexpensive treatment, if the treatment in question has never been shown to reduce morbidity and/or mortality.

The answers will not, of course, be easy. The first step, however, is to gather the necessary information in order to come to an intelligent, rational and moral conclusion. We still have much work before us. What we don't have is the luxury of procrastination.

Deuteronomy 37:7 (RSV) tells us: "Moses was one hundred and twenty years old when he died; his eye was not dim, nor his natural force abated." He had just climbed the 3,500-foot Mount Nebo where God gave him a vision of the promised land. That, I submit, is normal aging! Let us not prematurely push the elderly off lower ledges on *our* scramble to the mountain top.

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The Booming Elderly Population:
The Economic Crunch and Generational Equity

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Can America afford the booming elderly population? I don't think we are the first ones to ask this question, nor will we be the last. In asking this question, I believe we are making the assumption that the costs of the booming elderly population are, or will be, a social problem. And defining a social problem consists of two dimensions: a *factual* and a *value-related* dimension. I will first discuss the factual dimension.

Demographic and Economic Crunch

We are all aging, and we, the "aging," are here to stay in increasingly larger numbers. In 1900, people over 65 made up only 4 percent of the population; in 1992, that proportion ha risen to almost 13 percent; and by the year 2030, the elderly wil make up 22 percent of the population—an increase in the next 40 years of nearly 160 percent. And the most rapid population increase among the elderly will be of the "old-old"—those over 85 years of age and who are most at-risk for debilitating chronic conditions, loss of informal support systems (family, friends), loss of independence, and institutionalization.

What factors are responsible for these trends? The low birth rate in the U.S. in the last several years has influenced the proportion of the population 65 and over more than anything else. The other major factor is decreasing mortality, due in large part to the availability of high technology and the ability to prolong life primarily within acute-care settings.

At the turn of the century, a person's life expenctancy was about 47 years. Men who reach the age of 65 can now expect to live until they are 80, and women until they are 84. However, as people age, they are at much higher risk of developing chronic debilitating conditions that limit activities of daily living, and make them at-risk for increasing dependence. Thus, it is likely that those added years will not necessarily be active and independent ones, and that health-care expenditures will continue to escalate.

Generational Equity

The changing age structure in the U.S. that we have bee examining leads to frightening conclusions. Although those 65 years and over constitute only 13 percent of the population, they

account for more than one-third of all health-care expenditures. Almost 40 million people (many of whom are young) in this country do not have access to even basic health care. Thus, the question of generational equity often arises—"ARE THE OLD GETTING MORE THAN THEIR FAIR SHARE?"

There has been a feverish growth in health-care expenditures of 193 percent in the past 10 years, from 9.4 to 12.3 percent of the gross national product—compared with the consumer price index (107%) and federal education expenditures (63%). The impact of population and health-care expenditures projections on the U.S. economy will be of crisis proportions in 20 years unless steps are taken now.

A working conference and panel discussion at Loma Linda University, March 1 and 2, 1992, involving bioethicists and professionals in the field of geriatrics, debated issues of rationing health care for the elderly. There was general consensus that rationing is already being done to some extent. But our U.S. "health" care system is chaotic, and the rationing being implemented reflects this chaos (most agreed that the "health" care system in reality should be termed "medical" care system, because "medical" care is typically the only care reimbursed in the current system). And this is where the value-related dimension comes in.

Estes and Binney (1989) point out that in the U.S. there has been an evolution toward the social construction of aging as a medical problem, and that this view of aging has profoundly influenced not only the nature of our therapeutic interventions for the elderly, but the very way we define and approach this process of aging or growing old. They label this social construction of aging as a medical problem as the "Biomedicalization of aging." When we equate old age with sickness and pathology, we effectively disempower the elderly, creating an "iatrogenic dependency" and facilitating their social control through medical definition, treatment, and management.

Focus on Primary, Secondary and Tertiary Levels of Prevention

So, while many people continue to believe that health problems in old age are inevitable (again, within this framework of the biomedicalization of aging), a growing body of evidence reveals that a substantial number—the National Institute of Aging suggests up to 80 percent—of these problems are preventable, postponable, or at least controllable. The major causes of death among people age 65 and older are heart disease, cancer, stroke, chronic obstructive pulmonary disease, pneumonia, and influenza. Chronic problems such as arthritis, osteoporosis, urinary incontinence, visual and hearing impairments, and dementia, are of even more concern because of their significant impact on everyday living. To accommodate the changing needs of our increasingly older society, we must prevent the ill from being disabled, help persons with chronic disabilities preserve function and independence, and prevent further disability.

Many research studies demonstrate that changing certain health behaviors, even in old age, can benefit health and quality of life. This is also referred to as the "plasticity of aging," or the ability of the aging process to be shaped by individual behavior. When older smokers quit, for instance, they increase their life expectancy, reduce their risk of heart disease, and improve respiratory function. Good nutrition and physicial exercise are key in the promotion and maintenance of health in older adults. Diet can play an important role in mitigating existing health problems with older people. Often physiological decline associated with aging may actually be the result of inactivity, and increased levels of physical activity are associated with a reduced incidence of coronary heart disease, hypertension, noninsulin-dependent diabetes mellitus, colon cancer, and depression and anxiety. Moreover, increased physical activity increases bone mineral content, reduces the risk for osteoporotic fractures, helps maintain appropriate body weight, and increases longevity.

Can America afford the booming elderly population?

I believe we can if attention and money are targeted at health promotion/maintenance and disease prevention interventions at the primary, secondary and tertiary levels of prevention in all age groups—goals which are detailed in the DHHS publication (1990), *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. If interventions to achieve these goals are implemented, a drastic reduction in health-care expenditures, especially in the long-term care arena, will be realized; and we will be able to say emphatically, "Yes, America CAN afford the booming elderly population."

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LLU's Ethics Grand Rounds 1993-1994 School Year

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Our Burgeoning Elderly Population: Rationing Scarce Resources

James W. Walters, PhD
Professor of Christian Ethics
Faculty of Religion
Loma Linda University

Can America afford its booming elderly population? My answer is: sort of. The way that I put together the demographics of aging involves a threefold grid. First of all, I am forty-eight years old. I'm on the edge of the baby boomers and when I get to be eighty-five to ninety, there are going to be a whole bunch of us. You who are younger aren't going to know just how to take care of us because there are so many of us who are going to be coming on line. The statistics go from five times as many people who are eighty-five and older to ten times as many within forty or fifty years.

Let me suggest a second aspect of our topic. Not only will there be greater numbers, but those greater numbers of elderly folk are going to be living longer, perhaps a lot longer. The U.S. Census Bureau says that in forty years or so the life expectancy should go from seventy-four to eighty-one years—an increase of about six years. But there are researchers at the National Institute of Aging and USC's School of Gerontology who dispute that. They say that the U.S. Census Bureau is not taking into account breakthroughs that they anticipate from basic research in molecular biology. Small fruit flies and round worms have had their longevity doubled through certain genetic and nutritional procedures. Might this research apply to humans? Well, there's a big gap, but these researchers at NIH and USC are suggesting that the U.S. Census Bureau is very conservative, and rather than our living an extra six or seven years over the next forty years, we will live another fifteen or so years. Therefore, rather than the average life expectancy being eighty-one or eighty-two, it will more likely be ninety.

The third point is that there will be fewer people paying for the long-term care required by the elderly. The tax base is going to shrink. Now we have approximately four persons who are paying taxes for every retiree. In the era we're speaking of—some forty years hence—it will be more like two and one-half workers for every retiree. There will be greater numbers, greater cost, and a smaller tax base. I don't think we can avoid the word "crisis" when we talk about the sort of social demographics predicted for the years 2030/2040. What should be done about it?

I don't think, personally, that there's any way of avoiding thoughtful rationing, not just ad hoc rationing, of health care. How should it be done?

Let me suggest two approaches that are being contemplated. First there is *hard* rationing, and then there is *soft* rationing. I will mention two varieties of each.

When it comes to hard rationing, Daniel Callahan has written about the need to set limits. Essentially, Callahan says that when you get to be about eighty years of age you've lived your natural life span, and you should be willing to accept a tolerable death and let the resources saved go back to those who are just old—not "old old"—so that they can have a higher quality of life. We should address such medical problems as incontinence and arthritis—those sorts of ills that keep the old from having a fuller life. Callahan holds that after you get to be eighty the government should not fund any life-extention therapy. Zero! That, I would say, is a harsh form of hard rationing.

> *At eighty should you be willing to accept a tolerable death and save resources?*

Another form of hard rationing is that suggested by Norman Daniels in his book *Am I My Parent's Keeper?* He suggests that we, as prudent planners of how we want to have health-care dollars spent over our lifespans, would want to limit care given in old age. As prudent planners we would recognize that we want prenatal care given to all rather than making extensive ICU care available in the last few days of life. We would want all kinds of medical care given when we're thirty, forty, fifty—at the height of our lives—and not so much expended very late in our lives.

How much is spent late in our lives? Alan Greenspan, back in 1983, said that 28 percent of Medicare dollars are spent on patients in their last year of life—patients comprising only 6 percent of those funded by Medicare that year. Prudent planners might look at those statistics and say, "I want more money spent on me when I'm young and for twenty-year-olds who need transplants, but when I'm ninety I want you to cut back. Don't give me so much acute care in that last year, particularly the last month or two." That would be the less severe type of hard rationing.

Finally, there are two types of soft rationing. The first type involves use of professional practice guidelines. For example, groups like the AMA would get together and look at the Helga Wanglie case. The AMA would say to its physicians, "Physicians, let's get together and suggest, as a profession, to hospitals, Congress and to the President, that we don't think it is morally or medically appropriate to give extensive ICU-type care to those in a persistent vegetative state or in a permanent coma." Such a directive would not ask the government to make a new law; it would state that a specific professional society advocates particular guidelines that it thinks necessary for today's modern hospital.

A second type of a soft rationing is individual physician cuing. Take a patient who, in his/her eighties, has a cardiac arrest resulting in a quadruple bypass which didn't work out so well.

The patient continues to suffer, so that there is pump failure, leaving 15 percent capacity. After a few days, the arrest affects renal functioning and precipitates kidney failure. But with some of the superdrugs now available we can keep the patient in the ICU for maybe another month or two. DRGs have run out. The hospital is losing $100,000 a month on this patient, but life can continue. Should it? In this sort of case, following the model of individual physician cuing, the physician would take upon himself or herself the obligation to keep in the back of the mind the high cost of medicine and the low quality of life, and say to the family (because the patient is no longer competent to make a decision), "Mr. and Mrs. Jones, your mother is in this condition and my usual practice is to withdraw all of these special technologies and let nature take its course. If you don't object, this is what we'll do with your mother." Is this approach appropriate? It's not just laying out the facts in a neutral manner and saying, Take your pick: we can go for three months with all of the medical technologies available or we can let mom die peacefully. It's cuing the family toward a particular end. That is the second type of soft rationing which is being done now by some of our finest geriatricians.

Can we afford our burgeoning population of elderly? Yes. I personally think it is immoral to say that because a person is eighty years of age that life doesn't have the same value, the same moral worth, as a life such as mine. But when that life is near its end and the quality is very low, I do think this is an appropriate time for social prudence in the allocation of increasingly scarce medical resources in America.■

Update

Volume 10, Number 2 (June 1994)

Medicine and the Aging of America:
Nurturing and Caring for Older Adults

Reverend Thomas B. Robb, ThD

The author is pastor of the Presbyterian Church in Culver City, California. He is the author of *The Bonus Years: Foundations for Ministry with Older Persons* (Valley Forge, PA: The Judson Press, 1968), and *Growing Up: Pastoral Nurture for the Later Years* (Binghamton, NY: The Haworth Press, 1991). He has served as executive director of the National Interfaith Coalition on Aging (1988-1990), as director of the Office on Aging of the Presbyterian Church (U.S.A.) (1981-89), and as a project and program director for the National Council on Aging (1976-80). He holds the degree Doctor of Theology (1970) from the Graduate Theological Union, Berkeley, California, in the field of education and gerontology. His earlier degrees include Master of Theology (1976) and Bachelor of Divinity (1957), from San Francisco Theological Seminary, San Anselmo, California, and Bachelor of Arts (1953) from Arizona State University, Tempe, Arizona.

Carl Jung once proposed that life's afternoon must have a significance of its own, different from the rearing of the next generation and the pursuit of a career, which occupy life's morning. If we accept the premise that growth and development extend throughout the life cycle rather than ending with the attainment of physical maturation, as once thought, then concerns about nurturing and caring for those in later life must address issues of growth and development appropriate to the life stage which the individual currently occupies.

Growth and development can be thought of as a lifelong process of growing up, in which we gradually abandon assumptions about life and goals for our own growth adopted early in life in favor of assumptions and goals more appropriate to life's later stages. The years of later life can be described in terms of three periods. I like to think of them as acts within a self-authored and self-acted play. I label them early maturity, later maturity, and infirmity. They correspond roughly to the periods between the major events of later life: empty nest, retirement, onset of dependence necessitated by advanced chronic disease or frailty, and death.

The health, interests, activities and concerns of older adults vary markedly, but seldom change abruptly as they move through later life. The needs and concerns of those just finished with rearing children differ from those just retired, even more from those moving slowly through infirmity toward death. Concerns about life's purpose and meaning surface or take on new dimensions, particularly when careers end and spouses die. Attitudes toward death often change markedly from something awesome to be feared to something friendly to be welcomed.

People seldom become more religious as they age, but religion plays an important part in how they view and deal with their aging and inevitable death.

As a theologian, I begin with the assumption that life is created and that creation is an intentional act of the creator. That is, I believe that God has a purpose for creation, and each of us must find the purpose of our own lives within that overall purpose. Believing that we are created with free will, I acknowledge that one's purpose may be to cooperate with or to resist the creator's intent. Nonetheless, I remain convinced that each individual life requires a purpose.

In describing aging as a lifelong process of growing up, I mean to suggest that life always needs to be striving toward some future goal. The assumptions and goals adopted early in life often turn out to be inadequate as we age. We set out to be parents, then see our children become adults out from under our wing. We start out to pursue some trade or vocation, then retire from it. As we move beyond these basic adult activities, we need new goals and new directions for life.

Carl Jung's question has become for me a theological question: What is God's purpose or intention for life's afternoon? How shall we discern life's purpose and meaning once the children are grown and career has ended? As I wrestle with this question, I take hope from the ways others resolve it. They do not disengage, as social gerontologists once prescribed. Instead, they develop exciting and challenging new ventures and pursue them with creativity and vigor. Even when serious illness weakens the body or confuses the mind, they continue to strive toward valued goals, utilizing with imagination and determination the functions and energy that remain.

How physicians and clergy deal with older adults can support or defeat the efforts of the old and frail to continue to pursue goals and agendas that matter to them and give meaning and purpose to their lives. If we fail to take seriously those concerns, if we treat lightly their significance, we may do far more harm than if we disconnect life supports or withhold lifesaving procedures. We who are committed to the cure of bodies and souls must practice our healing arts so as to sustain and support meaningful life.

Here, then, are some concerns I believe both clergy and physicians must deal with:

1. Aging does not automatically bring infirmity or decline. The majority now live to advanced age with little or no debility necessitating dependence or intervention by others. The nurture and care of older adults must support whatever purposes the individual finds meaningful. Paternalism and manipulation are inappropriate.

2. Death is a part of life. Devotion to curing and healing must not result in unwarranted extension of the appearance of life when no purpose or meaning is served. In the case of believers, nurture and care must respect the patient's value system with regard to the use of life-sustaining measures.

3. When facing questions of prolonging life versus allowing it to end naturally, the well-being and wishes of the patient must be primary. Guidelines should be developed to protect the patient's compelling interest from being overruled by the requirements of the state or the value judgments of health providers.

4. Enabling terminally ill patients to die comfortably in accordance with their own sense of timing, and with the constructs of their religious faith intact, should not be construed as contrary to the canons of our professions. Requirements of law and professional ethics must be balanced by respect for the patient's life purposes and value constructs.■

The first three papers were presented at the March 4, 1992, Medicine and Society Conference. The last paper was presented at the December 5, 1990 conference.

Meet Our MA Students

This first year of our Master's program in biomedical and clinical ethics we were fortunate to have an excellent group of students from a rich variety of backgrounds. We are pleased to introduce them to you.

Debra Craig is an internist and geriatrician practicing at Loma Linda University, her alma matter. She is taking the MA program in biomedical and clinical ethics to allow her to teach and do consulting work, as well as better equip her to meet the complex needs of her elderly patients. Debbie is originally from the Midwest, and enjoys reading, biking and trips to the beach.

Pam Dalinis, originally from Elmhurst, Illinois, now lives in Las Vegas. She has a BS in Nursing from Northern Illinois University, and is currently working on a Master's degree in Ethics and Policy Study at the University of Nevada, Las Vegas. She is employed at Sunrise Hospital as a full-time clinical ethicist. Pam's interest in ethics began while she worked as a nurse in critical care, oncology, and hospice units. She plans to continue her work in the hospital setting, but also hopes to teach.

Rick Hongo grew up in Tillamook, Oregon, and still thinks it is "the greatest place on earth." Rick attended highschool in Japan and earned his BA in Theology from Pacific Union College. He has always been interested in ethics, and as a third-year medical student at Loma Linda University School of Medicine, is making good use of his time here by earning his Master's in ethics while in medical school.

Ted Masek is a radiation oncologist at Eisenhower Medical Center in Palm Springs. He received his medical training at Southwestern University in Cebu City, Philippines, and completed his internship and residency at Loma Linda University Medical Center. Ted and his wife, Julie, have three children, Tad, Michael, and Kara.

Hideko Nagata comes to Loma Linda from Kagoshima, Japan; (she reports that what she misses most are the four distinct seasons). She studied theology and social work at Pacific Union College. Hideko is combining the Master's program with the clinical pastoral education program also offered at Loma Linda, as she plans to be a hospital chaplain. In fact, Hideko has accepted a position at the Kobe Adventist Hospital where she will, according to our information, be the first woman chaplain in Japan.

Jana Neilsen is a Santa Barbara native, and recently completed a degree in business at La Sierra University. She worked for many years in a multi-disciplinary clinical agency for the developmentally disabled. Jana hopes to continue work in clinical health-care in the areas of patient advocacy and policy making, and will eventually pursue a PhD in social ethics. While a full-time student, she also works part-time for the School of Medicine.

Norman Pang is a native of Denver, Colorado. He earned a BS in Biochemistry from Pacific Union College. Norman is a third-year medical student at Loma Linda University School of Medicine while also studying ethics. He is not yet sure how his ethics education will fit into his professional plans.

Ronald Perkin is a professor and associate chair of the Department of Pediatrics at Loma Linda School of Medicine, and director of Pediatric ICU at Loma Linda Children's Hospital. As an undergraduate he attended the University of Colorado, and continued his medical training at the University of South Florida School of Medicine. Ron completed his internship, residency, and fellowship in critical care at the Dallas Children's Hospital in Texas. Ron hopes to join the clinical ethics service at LLUMC and provide consultation services in the Children's Hospital.

Amy Timmons grew up in Bangkok, Thailand, where her parents serve as Lutheran missionaries. She attended Seattle Pacific University and Pacific Union College where she studied ethical theory with an emphasis in biomedical ethics. Currently Amy works as the graduate assistant at the Faculty of Religion and the Center for Christian Bioethics at LLU. Amy has accepted a position at Concordia University, Irvine, and plans to spend some time teaching ethics as she earns her PhD.

PARK RIDGE CENTER CONFERENCE

November 3 & 4

The Park Ridge Center for the Study of Health, Faith and Ethics will host its first annual conference in clinical ethics, **Perspectives on Medical Futility: When Patients' Faith and Culture Compel Demands for Treatment**, on Thursday, November 3 and Friday, November 4, 1994, in Rosemont, Illinois. The conference is unique in its exploration of the cultural and faith aspects of medical futility, and participants will learn to assess and comprehend the cultural factors and belief systems that drive patients' demands for futile treatment. Faculty will include Larry Schneiderman, MD, Baruch Brody, PhD, and others with expertise in medicine, nursing, theology/religion, anthropology, philosophy and pastoral care/pastoral counseling. For information, contact Nancy Aldrich, The Park Ridge Center/S.M.H., c/o Lutheran General Hospital, 1775 Dempster Street, 4 E. Pavilion, Park Ridge, IL 60068; (708) 696-7847; (708) 696-3398 (FAX).

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