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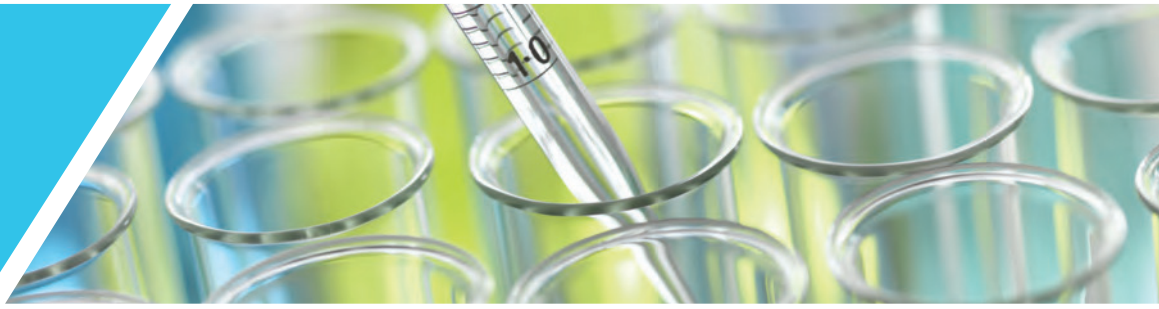

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Ageism in Health Care?

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I recently received, out of the blue, an email notifying me of what was deemed a particularly important letter to the editor of *Lancet* that I *had* to read (Lloyd-Sherlock et al). It accused the UN Sustainable Development Goals for Health of ageism. I was even given a link to allow me to set up a teleconference with the lead author of the letter, co-authored by several other British geriatricians. I've never gotten an email blast like that, and wondered why a letter about a UN recommendation would generate such heat. I noticed that the email blast emanated from the public relations department at the author's university, East Anglia University, and wondered if this was simply a way of advertising the university. Luckily the letter was available via a link, without having to decline an interview with the author.

Why did I become interested? Being a senior myself and having spent a small amount of time teaching neurology and practicing medicine in some very poor countries in Africa, and, at home, in a subset of what is sometimes considered "geriatric neurology," I thought that I might have some opinions that were at least partly informed by personal experience.

One percent of the American population takes 30% of the health care budget for their last year of life. Half of these are elderly. This is one starting point. Comparing the U.S. and the third world (aka "resource poor countries" in the current vernacular) is somewhat like comparing apples and oranges but the basic commodity is resources and the targets are people. In some ways, poor countries aim at emulating the wealthy, but not the American health care system.

For a variety of reasons, primarily that health care costs are rationed, poor countries have made choices that lead to multi-tiered health care on a routine basis. Since there is so little to go around, planning is more important than in the west. Government-sponsored care provides the bedrock for most people, supplemented in many ways by private funds. For example, in Rwanda, for $5/year, a citizen gets unlimited hospital level of care, including plain x-rays and medications that happen to be in the hospital pharmacy. Computed tomography, magnetic resonance imaging, medications not in the pharmacy, are paid for by the patient in advance, including transportation to the radiology site. The patient's family brings medications to the hospital. Private doctors and private clinics are used for most services by those who can afford them.

The letter opines that it is discriminatory for the UN millennial development goals to be "focused on maternal and child health and HIV, thereby reducing the available resources for other interventions. As such, it is expected… to drain resources from services of relevance to older people; services which in many countries are already woefully inadequate. Older people suffer higher rates of common conditions that are amenable to prevention and management and will contribute more to achieving targets for reduction in mortality and morbidity than focusing only on younger people."

As a "senior citizen," I am so stunned by this statement that I'm writing this column. We live in a world of limited resources, and, when not restrained, we suffer problems created by dying old people taking up precious resources that lead to denial of services to others. The United States is a good example of this. Poor people in parts of our country have health care problems that equal that of poor countries yet we drain even our own limited resources to pour them down a black hole. We are not all equals in the eyes of our communities and to think we are, in order to maintain a political consistency, reflects an old truism that "consistency is the hobgoblin of small minds."

What does it mean for old people to get the same resources as children, mothers and HIV patients? This is unclear. Poor countries with health care plans always invest in the public

health measures that produce the best return on the investment. These have traditionally been in sanitation, maternal and child nutrition, vaccinations, health screenings and high-yield disease prevention interventions such as DDT-treated mosquito nets. When affordable, preventive measures like blood pressure, cholesterol and diabetes control are included. In Rwanda the health minister pointed out that a patient pays less for HIV treatment than for diabetes. The problem with treating the elderly is that they require a great deal of investment and are not worth as much, in general, to their country. The notion of person-value is embedded in the American and other western legal systems used to determine compensation for injuries or illnesses. The amount of money given to an injured person or deceased person's family is partly determined by age. A younger person, with a greater earning capacity, is reimbursed more than an older person, closer to retirement. In addition, the older person, as noted above, will have much greater and more expensive health needs. And there are other reduced yields for the investment. Older people get sick again more quickly than the young. The investment in HIV has an even more compelling rationale. Aside from these patients getting sick in their most economically productive years, also putting their families at risk for financial catastrophe, they are public health hazards. Sick old people certainly jeopardize their family's financial security, but this is an expectation that societies have lived with forever. Old people get sick and die. This is in our genes.

The UN resolution does not call for not funding health care for the elderly, it simply de-emphasizes it. Perhaps they are trying to avoid the slippery slope of a health care system like our own, a model to be avoided?

We are not all equal. The responsibility of poor countries is to invest in public health, not necessarily to be age-fair. ❖

Author

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