left ventricular function. If a patient should suffer an embolic event then adding aspirin or increasing the target international normalised ratio (INR) range are to be considered.

Anticoagulation in patients with non-rheumatic atrial fibrillation is now of interest. This is prevalent in about 5% of the population over the age of 70 years with an annual risk of stroke of about 5%. Clinical trials suggest that this risk can be reduced to 1·5% with warfarin but this is associated with an excess risk of haemorrhage. The dilemma is to translate the information obtained in clinical trials to an individual who may be different to the study population, who has an inherent risk of haemorrhage, and whose ability to comply with therapy or with accurate monitoring of INR may be far from perfect. An alternative is to use aspirin, less effective at preventing embolic events but with a far lower risk of major haemorrhage. In general, patients with a greater risk of stroke, including those with a previous stroke, rheumatic heart disease, hypertension, heart failure and the elderly with lone atrial fibrillation, stand to benefit most from carefully controlled, long term anticoagulation.

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PRIORITIES IN HEALTH CARE OF ELDERLY PEOPLE: CONFLICTING IMAGES, CONFLICT OF INTEREST?★

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When discussing priorities in health policies for the elderly it is important to assess to what degree these policies are based on and shaped by popular misconceptions or fashionable ideas and ideologies. In fact, it may be argued that such assessment should be part of any kind of policy making. In this paper we address the issue of policy priorities in health care of elderly people. We observe that there has been a fundamental shift from a 'positive' to a 'negative' image of the elderly. This shift has been influential in recent social and health policies.

CHANGING IMAGES

In our view, there are four competing images about the elderly. The first is the traditional 'biblical image'. This image depicts the elderly as keepers of moral values; as heads of extended families, and as a source of knowledge and experience. This image is also reflected in the fifth Commandment: honour thy father and mother. Another biblical reference is Moses' Council of the seventy Elderly.

The second one is the 'policy image'. In this, the elderly are the object of government welfare and social security policies. The dominant view here is the equating of the elderly to poor and dependent persons.

Thirdly, there is the 'new modern image'. This depicts the elderly as a large group of healthy, self-assured and spending citizens. This image is reflected in the new publications for the elderly, with advertisements for cruise ship travelling, fashion, private home care and other services.

And finally, we see the 'new negative image'. In this, the elderly are seen as a group of self-centred, spending and, above all, costly segment of the population. They are perceived as the 'greedy geezers'.[1] This image has also entered our thinking about health care policies.

The last few decades have witnessed some remarkable shifts in societal ideas and ideologies regarding the elderly. These have also brought importants shifts in images. The traditional biblical one has virtually disappeared and been replaced partly by the policy image, partly by the new modern image. Recently, there has been a further shift towards the new negative image.[2,3] These shifts have led to conflicting interests between generations. The conflicts may be ethical, economic or political, perceived or not perceived, and within or outside health care. Some of the conflicts outside health care are particularly relevant as they may affect the shaping of health care policies. A few examples of such conflicts are as follows.

Almost all member countries of the Organisation for Economic Cooperation

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and Development (OECD) have embarked on extensive debates on the future of their welfare state including arrangements for social security and health.[4,5] The debates have mostly focused on the costs of social security. Implicitly or explicitly, the elderly have been assigned a negative image in this debate. They are regarded as gobbling up resources, crowding out other categories of government spending and threatening economic growth. Reports by the OECD and the World Bank based on long term extrapolations show that if current trends continue, we will be broke because of the burgeoning expenditures for the elderly.[6,7] Often, these reports use alarmist terms—Averting the Old Age Crises, Competing Problems, or The Old Versus The Young.

Starting in the USA, the welfare state debate has shifted emphasis from affordability of social security to intergenerational justice.[3] In the 1980s, political groups were rephrasing the debate and creating the new and mostly negative image of the elderly.[1,2] These political groups introduced the term intergenerational justice in order to argue that consumption by the elderly is syphoning financial resources from the young. As most pension systems are pay-as-you-go systems, they argue that the young are picking up the bill for the elderly. Another conflict concerns the economic dependency of the older generation. Changing demography, prolonged education and changes in the labour market have increased the dependency ratio dramatically. In this analysis, the elderly, as well as the non-working young and the unemployed, are seen as non-productive and thus costly. Demographic and social changes have led to more and more elderly living on their own rather than with families; they then become a visible minority and as such, an object of government policies.

Ending the biblical image brings an end to the mutual responsibilities of parents and children. In many countries, where the state has taken over responsibilities, children have no legal obligation to support their parents; reversely, the elderly have started to bother less about passing on their savings as a heritage to the next generation. Finally, increased life expectancy may bring conflicts about real estate ownership.

CONFLICTS OF INTERESTS IN HEALTH CARE

Within health care, there are several intergenerational conflicts, some are real and some perceived. The major conflicts concern costs. Extrapolation of consumption patterns in the past shows that health care expenditures will grow dramatically because of the demographic changes, the elderly being the main cause.[7] This has evoked all sorts of cost containment measures. One particular bone of contention is the age-related rationing of certain types of medical treatments.[8]

The intergenerational debate is implicitly focused on the degree in which the elderly are responsible for rising costs but in recent years it has become clear that ageing as such is not the most important factor. Almost all OECD countries have revised their predictions for various reasons. In health care, supply and demand interact. Supply side factors may be as important as growth in demand. The numbers of professionals, the capacity of hospitals and other institutions, and the rapid development of medical technology have all added to the intensity of treatment and the growth of health care expenditures. Ageing is but one, and certainly not the most important factor in the increase in health care expenditures. Consumer preferences for living independently and the expansion of home care services have slowed down the rate of institutionalization and thus the rate of

cost increase. Another point much debated are the medical expenditures in the last year of life. These costs (regardless of the age of the patient) may be very high. The Swiss economist Zweifel argues that the increase in life expectancy will not cause these total costs to go up, but will only cause a shift over time.[9]

There are other sources of conflict. Elderly patients may not want to accept the authority of a new and, in their eyes, very young doctor. Nursing home residents may resent the way in which young nursing aids address them. The consumer preferences of the elderly may not be compatible with existing provisions. Especially in extended health care, elderly patients express their own preferences. Often, they consider themselves as paying customers, and not as an object of government policy.

Existing financial arrangements have often been developed regardless of incomes. Some elderly consumers pay little or no direct charges for services, even when their incomes are high. In several countries, including The Netherlands, income-related charges have been introduced for home care and other services.

One particular issue in the debate is the question whether private insurance may be seen as a substitute or as an additional finance for collective funding of longer term care. However, there seems to be no way private insurance can guarantee access to essential long term care services at prices the consumers most in need can afford.[10,11]

However, it is not so much whether some of the arguments heard in the debate are right or wrong. The point we want to make here is that changes in images are instrumental in reframing the problems and issues and are thus influential in policy making.

WHO ARE THE ELDERLY?

At this point, it may be useful to try and find an appropriate description of the elderly before turning to some policy priorities. The first important aspect of the term elderly is the lack of clear and useful definiton. The traditional image of generations implies a clear cut distinction into three: the young, the (working) adult and the elderly. However, in our day and age this division has disappeared. We can distinguish at least 6 or 7 different 'generations', or specific population groups, each with its own views, demands and prospects.

The young and employed: often with double incomes, they have started to accumulate savings, investments and pension benefits.

The young and unemployed: this group has bleaker prospects, especially those with low education, lack of training and little experience; over time, they have low earning prospects and thus less opportunities to accumulate savings or pension benefits. They may be considered as the future poor elderly.

The adult working: with high accumulated savings and pension benefits, they own real estate and often have repaid the mortgage; the group owns investments and is looking forward to a healthy and wealthy old age.

The adult young retired: this group—let's say the 50 to 70 age group—may be characterized as healthy, wealthy and spending; often early retirement has been a well-prepared option; this group represents the 'new image' of the elderly and may be offended when labelled elderly; they certainly do not consider themselves as an object of our policy concerns;

The elderly healthy retired: the vast majority of our population over 65 is healthy; there are large income differences. In The Netherlands, a small percentage (about 15 per cent) is dependent on state pensions only, but the majority receive additional pension incomes; they also own real estate or savings and investment. Over 90 per cent of the people between 65–85 years old prefer to continue their independent living. In the USA, less than 1 per cent of persons between 60 and 74 are living in nursing homes or other institutions.[1] This group might be labelled as the 'new adults', who actively participate in cultural and civic activities.[12]

The frail but independent elderly: the majority of this age group considers themselves to be in charge of their own life. Often, the perceived degree of dependency differs whether seen from the point of view of the recipient or the provider of professional care. A minority of the population under 85 is in need of permanent medical and social care and support for daily activities. They may live at home, supported by home care services or may need some form of temporary or permanent institutionalisation.

The frail and dependent elderly: the last group of this list is the one most in need of permanent outside support and care, and who also need professional help in organising these. About 6 per cent of the age group 75–85 and about 25 per cent of people over 85 are living in nursing homes or retirement facilities in the US.[1] In Holland, this percentage is somewhat higher: about 28 per cent of the population over 80 are living in one of the institutions providing chronic care; thus the majority of our very old are living at home.

Studies of other characteristics of the elderly today show that persons over 60 are healthier and more active than previous generations; they are better educated and economically better off.[12] Large numbers of independent elderly are themselves providers of care for spouses, other relatives or neighbours. The frail elderly over 80 may have children who are ageing themselves, and are not healthy enough to provide care to their parents; this may lead a skip in generations, where grandchildren or cousins are taking care of grandparents or great uncles.[13]

Increasingly, the elderly show awareness of their own health. In Germany they go to health spas in order to learn more about healthy food and healthy lifestyles. Svanberg uses the term 'postponement of ageing' to indicate the importance of physical activity and healthy food for prevention of age-related debilitation.[14] He showed that even for persons over 90 years old, strenuous physical exercise may bring dramatic improvement in condition.

Rich elderly elites act as trend-setters in consumption patterns. They are vocal consumers, requiring good services and usable technology. Politically, the elderly have organised themselves in order to take back some of the power which they had lost in society. The last general elections in The Netherlands in May 1994 showed a surprisingly strong support for two new political parties by the elderly who felt neglected by the mainstream parties.

POLICY PRIORITIES

The changes in ideologies and societal images of the elderly are important to the shaping of political attitudes, and thus also to the shaping of health care policies.

Rather than a source of wisdom and advice, the elderly appear to have become a financial burden and are blamed for cost escalation even when only a small part of the increase of health expenditures can be attributed to their increased numbers. How does that conclusion affect our policy agenda? There are five points which are crucial to the formulation of our policy priorities.

First, we should acknowledge the importance of the images of the elderly. Replacing an image of the elderly as a homogeneous group by another image may not be helpful when assessing the need for government intervention. Rather, the current reality is of a heterogeneous population of elderly citizens consisting of working adults, early retirees, healthy and frail independent living, and frail and dependent elderly. The different images of the elderly are not so much competing; rather they should be seen as complementary, reflecting a growing variety in society.

Second, perhaps one of the first things to be done is to limit the term 'elderly' to persons over 70. In principle, persons under 70 (or maybe even under 80) should be regarded as mature adults, with independent living arrangements, independent views and accountabilities. The term accountability is used to express the conviction that the elderly themselves should be part of decision making in health care. Medical decisions should include careful and extensive consultations with the patients involved. Often, well-informed patients take decisions which may differ from the advice of the professional. We have to learn how to respect patients' preferences as the starting point for all treatment.

The third issue may be summarised with the term 'demography is no destiny'.[3] In the last few years, there has been an interesting debate between demographers and their critics. Demographers extrapolating current consumption patterns show dramatic escalations of pensions and health expenditures, if only because the number of elderly is increasing. Their critics argue that before we can extrapolate such trends, the current and expected changes in consumption patterns should be taken into account.

Fourth, we should be scrutinising the facts in order to distinguish fiction from reality. Before reducing pension benefits or limiting health care entitlements for the elderly, it is important to assess whether the diagnosis is right. For example, there are several factors determining the so-called dependency ratio which is crucial to the debate on the affordability of social security. Usually, this ratio is expressed as the number of non-working persons to the total population. However, it is more relevant to look at total earnings as the taxation base for the collective expenditures rather than at the sheer numbers of working and non-working persons. At present, the labour force shows important changes: a decrease in younger people, an increase in married women; a reversal of the early retirement trend and others. All these factors should be studied carefully before jumping to financial conclusions.

Fifth, it is clear that the differentiation of the persons over 60 requires changes in our policy thinking. The subgroups show a wide variety in consumption patterns and life styles. As consumer preferences differ, we will see an increased differentiation in services. The recent social insurance for long term care in Germany, the *Pflegeversicherung*, offers the option of receiving cash payments to persons who have been diagnosed for nursing home care, so that they may arrange for home care themselves. In The Netherlands, we have recently started a similar arrangement, the so-called personal budget for the elderly.

The rapid increase of the number of people over 85 may be expected to lead to increased demand for long term care. Part of this care will be provided by informal arrangements in which the elderly play an important role as providers, part will be paid for by the consumers themselves or by private insurance, and part by collective funding for institutionalised care. In particular, this last form of care requires government involvement as previously stated. There is no way in which the private insurance market can be expected to provide long-term care insurance for all groups in need of such entitlements.

In the last chapter of his revised book *The New Politics of the NHS*, Rudolf Klein argues that the British health care system is at a cross-roads; it has to choose between the 'garage-model' versus the existing 'NHS-model'.[15] This dichotomy in options may be less sharp. Perceptions about the elderly are changing, as well as perceptions of the elderly about themselves; so are their actual positions. Governments will have to reassess their policies, leaving more room for differentiation.

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ETHICAL AND ECONOMIC DILEMMAS IN THE NHS*

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An ethical dilemma for government is to decide what proportion of public expenditure should be spent on health care. In the United Kingdom it is just over 7% of gross domestic product (GDP) and ranks seventeenth amongst OECD countries with only Spain, Denmark, Portugal and Greece spending less. The UK spends approximately £750 per head whereas Germany, France and the USA spend between £1,500 to £2,000. Ideally the allocation of finance requires expenditure to be linked to measures of health outcome. Measuring health outcomes is difficult and complex, and a decision to allocate resources is often influenced by political factors which may have little to do with anticipated health benefits. The simplest form of linkage is between life expectancy and expenditure. For example, some Central African States, where life expectancy is 39 years, spend $60 per capita per annum on health; in the USA, where life expectancy is 78 years, $60,000 is spent. Life expectancy of course depends on many socio-economic factors related to direct expenditure on health care. In developed countries much of the huge cost of health goes towards improvements in the quality of life and has relatively little impact on life expectancy, compared with that of the direct care in poorer countries. While there is no immediate panacea to the problem of resource allocation at a national level, the problem is all too real however at the levels of local health boards and trusts where real rationing decisions have to be made. This leads to significant ethical and economic conflicts for doctors and managers.

RATIONING

There is no generally accepted, nationally applicable, ethical principle which can be used to resolve conflicting claims on limited resources. As Klein has observed, the process of rationing begins from the moment a patient enters a general practitioner's surgery. This may take the form of rationing by deference, rationing by delay, or rationing by dilution, and even rationing by discharge.[1] All of these methods of rationing within the system are less than explicit. Furthermore the basis of rationing decisions taken by Health Authorities and purchasing teams, when deciding on resource allocations are also often less than explicit. None the less, these bodies are beginning to make explicit rationing decisions and it is not uncommon for Health Authorities to have exclusion lists of treatments that will not be purchased, for example removal of a tattoo.

Some local Trusts have attempted to make this process more rational and explicit by involving management and the doctors in decisions on resource allocation at the earliest possible opportunity. In the Edinburgh Western General Hospital Trust for example, budgetary authority is devolved to Clinical Directors who have responsibilities for both income and expenditure, and increasingly, for

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