



## Our Health Care System Cannot Afford Its Customers

by Morton C. Creditor

I have just celebrated my sixty-fifth birthday. I am officially old. I am eligible for Social Security and Medicare. From now on I will be a statistic in the old column in every demographic breakdown of data from medication usage to prevalence of dementia and incontinence. It is unlikely I will ever be considered in polls relating to beer consumption, clothing style preferences, sports cars or racing sloops.

I chose the word "celebrate" deliberately because the fact that almost all of us will get old, most very old, should be a cause for celebration. It is a triumph. We have survived all of the risk factors that have cut down most of our ancestors before they could enjoy retirement.

However, I am reminded almost every day by the popular press, television, and my professional journals that I am part of a growing problem. Instead of my aging being viewed as a societal achievement to be celebrated, it is viewed as a societal problem to be solved.

And no wonder. The aged have suddenly appeared in large numbers. Within my own lifetime, the number of people in the U.S. over age 65 has increased from 5 million to over 25 million; from less than 5% to more than 11% of the total. The life expectancy of infants born in 1900 (about 2 million of whom are still alive) was only 49 years. It is now about 79 for a white female born in America. These enormous changes have occurred intragenerationally, allowing little time for societal adaptation.

The old folks suddenly appeared like a wave of immigration and, as with any wave of immigration, you recoil, react, develop biases, and invent ethnic jokes.

As is the case with any wave of immigrants, they must first be characterized and defined if we are to develop programs to address their needs and integrate them into our society. However, all such labeling for purposes of defining entitlements more often ends up defining the limitations of entitlements. I will come back to that later.

On the other hand, the individual "pseudoimmigrants" have no personal perception of this change, unless their trip to the Social Security office can be equated to sailing up the bay past the Statue of Liberty. They began to get old the day they were born. They get older every day. This is a continuum in which none of us as individuals can pick out the moment when we are "old." I will further develop this thesis by personal example.

I did not feel any different about myself on my sixty-fifth birthday than on my fortieth or twenty-fifth. My professional and avocational interests continue, including a recent career change, a new hobby (sailing), a return to an old interest in gardening, and a continuing interest in physical fitness and jogging.

My political orientation is unchanged, my appreciation of a pretty painting or a pretty girl is no less than in my twenties and, most importantly, I have a continuing sense of future. Consciously and unconsciously, I think about and plan for tomorrow, next weekend, next vacation, and next grant application. I continue to be me. I continue to project the same values and aspirations that have accumulated from my past experience.

I want the opportunity to continue to be me—to be considered as an ordinary person. But I expect something

more as I get older. I expect status. I want to be considered venerable, which according to the dictionary means worthy of reverence or respect by virtue of dignity, character, position or age. I speak not only for myself but for almost everyone, because almost everyone will get old. There is no acceptable alternative.

We have paid our dues in such forms as Social Security and contributions to other retirement benefits. We have contributed to the progress of the world during our generation. Those who follow enjoy the benefits provided by their elders. Each generation rides into the present on the backs of their predecessors.

Karen Davis, in stating the public policy rationale for health care for the aged, includes repayment for past contributions to society. She points out that "the aged supported the education and investment in human resources of their children and other members of society. They have forgone consumption to permit accumulation of capital that serves to improve productivity and

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standard of living of today's younger generation. They have contributed as taxpayers to the creation of a social infrastructure including highways, railbeds, dams, bridges, sewer systems, schools and hospitals that serve the younger generation. They have fought in wars to assure freedom for succeeding generations. This debt is one rationale for public policy that repays the aged as a group with programs that assure a decent old age."<sup>1</sup>

For these reasons I find the thought of social regression morally repugnant. I cannot accept the idea of being discriminated against as the reward for reaching venerable status. I do not want to be prematurely assigned a clinical career—to be converted from person to patient without compelling reason. I do not want my entitlement to be considered a charity nor do I want to become the beneficiary of a welfare agency.

But all of these things are likely to happen to me as part of my designation as a "senior citizen," particularly if I become a sick "senior citizen" because the health and medical care system of this country cannot afford me—its most frequent customer. Furthermore, the reasons the system cannot afford me are actually inimical to my best interests in terms of my health and health care.

This country is reeling under the burden of the costs of health and medical care. We currently spend 11.1% of our gross national product on health and medical care, more than any other country in the world. We boast that we have the Cadillac of health care systems but we have little evidence of superior performance. The Japanese expend 6.7% and have the longest life expectancy of any country in the world, almost three years longer than for American women.<sup>2</sup> Almost every developed nation does better than we in infant mortality.

All of those other countries that spend less than we do on health care provide universal access to care for their entire population. In the United States 37 million people do not have resources to cover the cost of their medical care.

In most other nations physicians are still held in high regard and continue to provide professional leadership. Here the diminishing stature of physicians is a matter of serious concern to the profession, and the costs associated with professional liability are a problem for everyone. Medical decisions formerly made by physicians are becoming increasingly influenced and even

dictated by agents and agencies not involved in the doctor-patient relationship. We have almost universal unhappiness with the issues relating to long-term care.

Care of the aged accounts for a disproportionate share of the almost 550 billion dollars expended annually on health and medical services in this country. Although the aged comprise 11% of the population, they occupy about 41% of hospital beds. About 30% of drug utilization can be ascribed to those over age 65. More than 90% of the 1.4 million nursing home beds are occupied by the aged. Thirty percent of the total expenditure on health and medical care is on behalf of the 11.3% of individuals who are classified as old.

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### Why is medical care in the United States totally inappropriate in addressing the needs of its major customer, the aged?

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Furthermore, we can anticipate rapid increases in total costs of care solely on the basis of the continuing aging of the population, inflation and technological change notwithstanding. By the year 2000 the 25.5 million over 65 representing 11.3% of the population will increase to 35 million or 13%. The very old, people over 85, who consume the most resources will increase from 1.1 million to 2.24 million. By 2030 there will be 64.6 million (21%) over 65 and 8.6 million over 85.<sup>3</sup>

Simple arithmetic predicts increases in cost that cannot be offset by reduced production of B1 bombers, MX missiles, or any other of the popular proposals now extant. The projected increases will be greater than will be tolerated by the public, nor should they be tolerated, because a large share of that cost is unnecessary cost—outrageous cost. Although the public outcry will be based on cost, it should be emphasized that factors which contribute to the outrage are not good for the health of the population. In fact, the emphasis on cost distracts attention from the real problems for which high cost is a surrogate—overutilization, inefficient utilization, counterproductive utilization of health and medical resources.

Unless there is dramatic change in the way we do our health care business, the aged will be the victims

of further cost containment efforts. Age-specific discrimination in the provision of care is predictable. The aged are the obvious targets because they are the major recipients of health and medical care, they are specially categorized and visible targets for special treatment and they have what would appear to be a special entitlement which can be publicly controlled.

Why is medical care so expensive in this country? Why in spite of its cost is it apparently less effective than in other countries? Why is medical care as delivered in this country totally inappropriate in addressing the needs of its major customer, the aged?

### Acute Care Orientation

The health and medical care system in this country is oriented towards acute care. The accelerated evolution of the modern care system began with the antibiotic era, the rapid differentiation of practice into specialties and subspecialties, and the introduction of dramatic life supporting and life sustaining technologies. The treatments of chronic problems such as tuberculosis, syphilis, and mental disease were revolutionized and the large institutions created for their care disappeared or were converted to other purposes. General purpose chronic disease hospitals either closed or were greatly reduced in capacity and importance.

The gravitational pull of the acute care hospital, which is oriented towards cure and dramatic rescue, became greater and greater until it became virtually the only focus around which the important action took place. Even in the case of chronic conditions the hospital's pride is in the provision of the heroics such as transplantation, bypass, dialysis, joint replacement, or bowel resection. The hospital attitude towards chronic disease is reflected in the groans and moans of the house staff when the patients with chronic arthritis, chronic congestive failure, chronic bowel disorder, recurrent sickle cell crises, or diabetic gastroparesis, for which there are no quick fixes, are readmitted for the umpteenth time.

But quite apart from the discomfiture of the hospital caretakers, there are other problems associated with the acute care focus. The acute care hospital requires expensive technology, particular personnel trained for uniquely specialized tasks, and an ambience attuned to the dramatic and unexpected. Acute care is properly very expensive. Chronic care has a different set of requirements both in terms of

technology and human resources. First strike capability is not required nor are the associated costs. The choice is now between the \$500/day hospital and the \$65/day nursing home. Neither is appropriate to the needs of the great majority of institutionalized aged who need mainstream health care in a "\$150/day" chronic disease hospital bed.

A longitudinal orientation is required for care of a population with chronic conditions. The continuance of underlying problems should be acknowledged, the need for regular tuneups should be scheduled, the likelihood of exacerbation anticipated. The care institution or the system of care should include a spectrum of resources that most appropriately addresses the spectrum of potential needs.

It follows that there must be continuity. The same set of caretakers should be involved in the care of the aged wherever they reside at any particular time. Currently, strangers are likely to take up the care of aged people as they are moved from home to hospital to nursing home or day care center. The confusion in the traffic flow is so great that "case managers" are needed to assure linkage if not continuity. The cost of discontinuity will be discussed below.

### **Unconstrained Application of Technology**

Medical care is more expensive than it should be because of the unconstrained application of technology just because it's there. It is a splendid technology which contributes greatly to our diagnostic abilities and therapeutic achievement. However, more is not better and, in fact, overuse of technology is no less a transgression of good care than failure to use an indicated procedure.

It is reported that 20% of the cardiac pacemaker placements are not indicated and 36% questionable.<sup>4</sup> Only 35% of carotid endarterectomies were deemed appropriate by a recent analysis.<sup>5</sup> In another study only 72% of upper gastrointestinal endoscopies were considered to be appropriate.<sup>6</sup> There are enormous differences in the rates at which operations such as hernia repair, appendectomy, cholecystectomy, prostatectomy, hysterectomy, hemorrhoidectomy, and tonsillectomy are performed when different countries are compared, when regions of the United States are compared with each other, and even when communities in

the same state are compared.<sup>7 8 9</sup> Clearly these differences are not based on differences in the clinical needs of these different populations.

The evidence supporting the use of many of these technologies is limited and, although medical knowledge is steeped in scientific discovery, much of medical practice has not been subject to the rigors of the scientific method.<sup>10 11 12</sup>

Unnecessary use of these procedures is associated with unnecessary cost. But even more important, all of those operations and pacemakers and endoscopies also carry significant risk of morbidity and mortality, which create further cost.

Large sums are also wasted in the routine use of "small ticket" technologies.<sup>13 14</sup> There is impressive evidence that routine use of laboratory test batteries, urinalyses, chest x-rays, and electrocardiograms are of little utility. So-called baseline studies without specific indication rarely serve as baseline for anything. Nor are they without risk. A laboratory error or the occasional aberrant result without clinical significance can result in the use of procedures which do bear risk as the fruitless search for explanation proceeds.

### **The Subsidization of Obsolescence**

There are thousands upon thousands of empty hospital beds in this country and most of them were empty before the advent of DRG's upon which everyone would like to heap the blame. The fact that these beds are empty is evidence in itself that they are unnecessary. Yet every impending hospital closure is looked upon as a disaster. Shouldn't we view the diminishing need for hospital beds as something to celebrate? I know of no evidence that hospitalization in itself is a good thing. For the aged the hospital is a very high risk environment mined with opportunities for iatrogenesis. It is an interesting coincidence that mortality rates among the aged have been declining parallel to length of hospital stay.

Unfortunately, hospital closures put people out of work, but hospitals are not intended to be employment agencies. Also unfortunate is the fact that the hospitals that do fail are often in locations where they are needed the most.

But empty hospital beds create unnecessary expense just by their existence. By being included in a

particular hospital's capacity they contribute to the demand for ancillary support such as laboratories, x-ray, CT scanners, etc. Perhaps most importantly they force the hospital (usually "not for profit") to go into heavy competition for the remaining business and to find means to subsidize the losses which the beds alone are likely to incur.

To compete hospitals have created marketing departments and marketing campaigns more eye-catching than those of Marshall Field and Macy's. They have restyled the hospital and added enticing luxuries that could put them in competition with Hilton or Hyatt for the weekend vacation crowd. They have added self-aggrandizing additions to their names and their component parts have acquired exotic titles like "Birthing Center."

To subsidize hospitals, many of which have become complex conglomerates, "small businesses" have been spun off as for-profit subsidiaries. Some of the services provided by the subsidiaries have yet to stand the test of scientific validity. Some cannot even be considered health related business.<sup>15</sup>

I will name just a few which can be seen advertised in the newspapers, yellow pages, weekly magazine inserts, and junk mail. They include stress management centers, alcohol and drug abuse centers, adolescent problem programs, a couples resource center, breast health centers, rectal care centers, weight control centers, liposuction centers, Excess Express (a cab service for drinkers), lifestyle (fitness) centers, health education centers, catering services, coping with divorce classes, and assertiveness training centers.

In addition to just subsidizing the deficits, these enterprises and others such as HMO's are intended to steer their customers towards the hospital's intended functions in time of need. They are the means for increasing "market share."

### **Lack of Rational System**

The most important reason for the outrageous cost of health and medical care is the total absence of any rational system of health and medical care. There is no basis for rational allocation of resources. There is competition for market share, but the market has never been defined. Except for HMO's, no individual or institutional provider can identify the population for which it or he or she has responsibility. In some urban areas it is

not unusual for two or three or more hospitals to be physically located adjacent to each other, each calling themselves community hospitals.

How can rational, cost-effective decisions be made about how many beds, how many CT scanners, or how many orthopedic surgeons are needed if not even the size of the population or its demographic characteristics can be defined for any particular provider? No wonder that the so-called system of care is characterized by expensive redundancies in some services and pathetic shortages or absences in others. In the absence of empirical data which relate resources to needs, it is easy to promote the principle that more is better, and at the same time tolerate such situations as that recently reported in the Chicago newspapers. The entire south side of Chicago will soon be without a designated trauma center. The two hospitals which in past years successfully competed for the then profitable designation, have decided they can no longer afford the honor. It seems unbelievable that in this country a whole community can be held hostage to private decision-making of this sort.

The lack of system militates against the provision of continuity of care which is so important in the management of aged individuals, particularly those with chronic disease. Furthermore the cost of bridging the discontinuities is very great. A typical elder may see his or her internist in one place and ophthalmologist in another. If hospitalizations were required, it might be in one place for the cataract and another for pneumonia. If rehabilitation care, nursing home care and home care were required, separate, unrelated institutions and agencies would be likely to provide each.

Each new caretaker is a stranger. Each will have to start all over in learning about the patient. Each may find it easier to start from the beginning than to try to get useful records from the other on a timely basis. Each will use reams of paper repeating over and over again, "this umpteen-year-old white female, etc., etc., etc.," re-asking and re-recording unchanging information like date of birth, operations, immunizations, allergies, etc. There is no case management program which can compensate for the lack of continuity of caretaker responsibility that is characteristic of our so-called system of care. What we call free choice care is unconscionably expensive and inherently poor.

It has been calculated that 22% of

the cost of our most expensive health care system in the world can be ascribed to its administration.<sup>16</sup> Anyone who has been a "beneficiary" of health insurance and has received the flood of bills and computer printouts which follows a simple hospital service can appreciate the reason for the \$10.5 billion "overhead" cost of commercial insurance programs. Add another \$5.1 billion for governmental and other private plans. Much of the rest of the administrative costs are caused by the programs introduced to control costs and insure quality.

### Professional Liability

The cost of professional liability further escalates the rate of increase of health care costs. It is almost as if the public expects perfection for the high price they are paying for their care. Although no attempt will be made here to place fault for this costly "waste product" of the transaction between patients, the care system, and the legal profession, it cannot be disregarded as an important component of health care costs.

### Long-Term Care

About 5% of the population over age 65, about 1.3 million people, reside in nursing homes and about 20% will spend some time in one before they die. The number in residence will increase to more than 3 million by the year 2030. According to the House Aging Committee, 69% of single, aged individuals would be impoverished after 13 weeks in a nursing home and 94% within a year.<sup>17</sup> Of course the newly impoverished elder becomes eligible for Medicaid support, but Medicaid is not an entitlement for becoming venerable. It is a welfare program. It is a charity which makes a formerly independent contributing member of society a second-class citizen.

Furthermore, the nursing home is an inappropriate institutional form which few, if any, want to enter. It is not a home because it functions according to the rules of the clinical paradigm. It consigns people to clinical careers, loss of privacy and autonomy, and a life governed by doctors orders. For those who need clinical care in the mainstream it is a poor surrogate for a properly designed chronic disease hospital. It is an enormous cost center and about 80% of it is located in the for-profit sector.

### Nothing is Working

Since the mid-1960's numerous at-

tempts have been made to stem the tide of rising cost. The Johnson administration's Great Society initiatives included the Regional Medical Programs and Comprehensive Health Planning (CHP). The former provided incentives to the academic establishment, the practicing professional, and the providers to join in "regional cooperative arrangements" to increase the efficiency and effectiveness of delivery of care, particularly for the big killer diseases—heart disease, cancer, and stroke. CHP was a consumer-public official partnership for purposes of long-term rational planning.

Both programs suffered political indifference within five or six years and were replaced by congressionally mandated public utility types of control mechanisms. Examples included the requirement for certificates of need to create new resources, Professional Services Review Organizations, followed by Professional Review Organizations (PRO's). Certificate of need is

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disappearing state by state. PRO's currently function on behalf of Medicare and virtually every other third party insurer has imposed its particular PRO process on providers. The latest control is that of prospective payment with the Diagnosis Related Group (DRG) as the most recent refinement: No wonder the enormous administrative cost generated by the so-called system.

Simultaneously there has been the attempt to let good old U.S. capitalism rationalize the system and competition has been introduced as the natural rationalizer. We now have alternative systems of care which include HMO's and Preferred Provider Organizations (PPO's). Large, national for-profit corporate entities now run hospitals, nursing homes, and "Doc in a Box" ambulatory facilities. Some of the HMO's which opened enrollment to elders have lost their shirts.<sup>18</sup> The for-profits have slowed their rates of growth and are selling off some of their facilities. Unfortunately the usual laws of capitalism do not pertain. The consumer can't evaluate the product and often cannot refuse to buy. Supply and demand do not regulate this marketplace.

Nothing is working. The costs are continuing to escalate. They rose 9.8% in 1987. Providers, patients, and government are becoming more and more unhappy. It is estimated that almost 12% of our gross national product will be spent on health care by 1990.

The costs continue to increase because with new technology the acute care hospital becomes more expensive while the numbers of individuals requiring chronic care increase. Nor have we been able to discourage the unconstrained application of technology. Our reward system continues to favor the use of technology and our medical educational system glamorizes the technology and its rewards even in the absence of vigorous proof of effectiveness. The large corporate hospital enterprises (for-profit and not-for-profit) fund new and better ways to prop up their loss leader as isolated rural or inner city hospitals fail. The courts reverse legislative attempts to modulate the professional liability awards. Few are willing to suggest that the basic structure needs modification and what changes are being made tend to shift the aged from the expensive and inappropriate hospital bed to the undesired nursing home bed.<sup>19</sup>

In spite of Medicare the out of pocket expense for elders has continued to increase as a result of deductibles, co-payments, increased premiums, and limitations of coverage. The new catastrophic insurance program will improve the situation for a few Medicare recipients. It will increase the burden of cost on the system itself. It will not alter the fact that many economically marginal elders become poverty stricken when they become ill.

In spite of an expenditure of about \$550 billion on the "cadillac" of systems, most people who need long-term care are forced to become members of the welfare society, are consigned to clinical careers and find themselves without much of a sense of future.

### Something Must Be Done

Something will be done because something must be done. The public will not continue to tolerate annual 20-50% increases in their health insurance premiums. What is likely to be done has ominous implications for the aged since they are the most obvious target for the next attempt at cutting health care costs. They are the largest customer, they are like immigrants

clearly identified and characterized, they are a minority and they have a controllable entitlement. Senior citizens are sitting ducks for the next phase of cost containment.

However, I am not willing to accept social regression because of my old age. I resent the possibility of becoming impoverished and a member of the welfare society as a reward for my achievements. I am frightened by the prospect that I might be consigned to a clinical career and a setting in which tomorrow is not worth planning for. As a physician I can assume my own continuity of care, but I empathize with many of my patients who came to me in their eighties as strangers and have yet to entrust their care to other strangers as they wend their way through our existing system.

The next step in controlling cost will be rationing. There are numerous definitions of rationing<sup>20</sup> including Webster's Third New International Dictionary which says "to distribute or divide (as commodities in short supply) in an equitable manner." All of us over 65 experienced and understood the need for fair sharing of limited resources during World War II. But the rationing which is now being hinted at by ex-governor of Colorado Richard Lamm, or by Daniel Callahan<sup>21</sup> and others, is undisguised discrimination, not equity. It is the withholding of some form of care which would be expected to do good, solely on the basis of age.

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That is morally offensive. Although I may be viewed by the rest of society as an immigrant or member of a minority, I view myself exactly as I have always been. As I indicated earlier, I believe that I deserve special consideration. I not only do not want to be discriminated against, but I want a system of health and medical care that is more appropriate to my needs, the needs of its most frequent customer.

Ethical as well as economic considerations demand that something be done. The current trajectory will propel us into ethically unacceptable solutions. No amount of tinkering with the present system will change my prospects for a venerable old age if I

become chronically sick. It is time for sweeping change and there is evidence of increasing public support for change.<sup>22 23</sup>

First of all we must adopt a universal scheme that is applicable to all. It is one of the anachronisms of our society that access to the health and medical care system is dependent upon economic status or that needed care might be out of the economic reach of anyone. But on behalf of the aged I agree with Karen Davis who states "the foundation of health policy for the aged must be a health care financing plan encompassing the entire population."<sup>1</sup>

However, I go further because we cannot afford any plan for financing the current irrational system of care even without the burden of universal enfranchisement. I agree with those who would put "an end to patchwork reform of health care."<sup>22</sup> We need a rational system of care in which the needs can be empirically defined, in which the parts relate rationally to each other, in which continuity of care is possible, in which redundancy can be minimized, in which administrative costs are reduced, in which quality can be monitored and assured, in which there is a basis for appropriate allocation decisions.

It is only in such a system that we can determine how many beds we really need, where they should be located, and whether they should be acute care beds, chronic care beds, or long-term care beds. It is only in such a system that we can rationally relate the beds and ambulatory services and home care services and day care services to each other and for the patient to enjoy continued care by the same groups of physicians, nurses, and other health professions, wherever they happen to be in the system; where progress notes can be entered in the same record in consecutive order without need to start a new record or wait for the summary which might or might not be received from the other hospital, x-ray department, or doctor's office. A system in which services can be utilized without regard for which particular ones will be paid or by whom.

A unified system will also provide a basis on which we as a society can decide how much of our total resources we wish to allocate for health and medical care. Resource allocation is an ethical means for making decisions about differential use of societal resources since it does not apply at the level of the individual

patient. It is my contention that with rational resource allocation we will be able to avoid discriminatory rationing.

If the billions consumed in administering the insurance system were eliminated and some of the other costs of administration were reduced, we might (without doing much else) be able to afford needed care for everyone without considering rationing or other forms of individual discrimination.

We must also continue measures for evaluating the effectiveness of all modalities of care, low ticket as well as high tech. The potential dollar savings are considerable, the human benefit immeasurable. The measures of effectiveness, the quality of care in general, and the assessment of technology would all be improved and simplified in a unified system of care in which the denominators are more sharply defined: A system of care in which the leadership can be identified so that it can exercise leadership.

Eddy and Billings<sup>10</sup> ask the cogent questions "... Who has the authority or the resources for implementing whatever is agreed on? Who is accountable fifteen years from now if no progress has been made? A basic fact of the American health care system is that there are no good answers to these questions. This is because our system does not have a leader; it has dozens— each with different but overlapping domains and interests. Furthermore, there is no mechanism for both developing and executing a common vision."

Many of my physician colleagues will deride me for suggesting that they give up their professional autonomy and become civil servants. But our professional autonomy has been eroding for quite some time now. Many forces now dictate how we practice and that includes practice mode as well as individual patient-related practice decisions.

The most blatant dictator of our practice is the DRG. But think of the PRO, the PPO which most physicians have joined as a matter of survival, the influence of potential litigation, limitations on prescribing, second opinions, insurance forms, etc. Many physicians have been employed by the Veterans Administration and state universities and have maintained high professional profiles. It is estimated that 40% of new graduates are accepting salaried employment with HMO's, groups, hospitals, and for-profit managed care systems. Some are finding that employment in the private sector may place

demands on professional integrity from a number of dimensions.<sup>24 25 26</sup> It is my opinion from a brief sojourn in the British Health System that the physicians there enjoy more professional autonomy and certainly more patient and public respect than many physicians in this country. They continue to make professional decisions within the boundaries established by public policy. In this country the physician is

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In this country the physician is harassed by regulation as it applies to doctor-patient interactions.

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harassed by regulation as it applies to individual doctor-patient interactions.

Whether I and the 25 million people 65 and older are to enjoy their later years as fully enfranchised citizens in spite of a likelihood of some illness or disability depends on what happens to the configuration of the health care system and the cost of health care. Therefore we must focus our attention on creating a system which is appropriate to the needs of its most frequent user, which is affordable so that universal access is possible, and which is not only effective but lends itself to ongoing measurement of effectiveness. These requirements can be met only by a unified national system of care. It is the only ethical way to go.

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# A Sociology of Aging

by Bruce M. Zelkowitz and Karen L. Field

Formally founded in the early nineteenth century, sociology is a comparative newcomer among the sciences. But despite its youth, it is fast becoming a valuable tool for exploring complex issues surrounding old age. Combining their own insights with those from related fields like anthropology and history, sociologists are posing new questions about the later stages of the human life cycle and coming up with some provocative answers. The purpose of this paper is to explain how a sociologist goes about the analysis of a subject like "aging," to sketch the current direction of research and some of its ethical dimensions, and to explore a few of its implications for social reform in America.

In attempting to understand some particular facet of human behavior such as love and marriage, parenting, crime and addiction, war and peace, or, in this case, aging, sociologists start from the premise that all human behavior takes place within a specific sociocultural setting, apart from which it cannot be understood. That setting is conceptualized as consisting of **economic forces**, the ways in which necessary, valued goods are produced and distributed; **political forces**, the ways in which power and decision-making are structured; and **ideational forces**, the concepts, beliefs and imagery by which people give meaning to their experience. In what is called the "political economy" approach, economic forces are taken to be the most basic and influential of the three. At first blush this may seem like a cliché, but a moment's reflection will show how, in everyday life, we often make quite contrary assumptions, attributing causes to panhuman **species factors** ("it's natural for human beings to 'go downhill' as they get older") or to purely **individual factors** ("you can stay fit well into old age if you just put your mind to it") rather than to **sociological factors**. Instead of blaming "human nature" or individual laziness for late-life decline, a sociologist would want to determine if, on the basis of available data, certain configurations of economic, political and ideational forces seem more conducive to healthy aging than others, and if so, why.

Consider the following real-life example. Many today decry the low regard in which modern America seems to hold its elderly. Recognizing that this problem is too widespread to be considered a mere foible, sociologists reject the assumption that a tendency to devalue the elderly is innate in the human species. Looking through the literature on other cultures, they identify cultures that accord high status to their elderly, then try to identify which features seem to account for the difference. One pivotal economic factor appears to be the presence or absence of writing technology. In preliterate societies where no method exists for recording the past, the elderly are often prized for their long memories. Marjorie Shostak has lived among Africa's !Kung San people and says of the older !Kung woman:

... Age should still bring her respect, especially as she is looked to for the stories of the past, whether mythic or historical. . . . She knows the histories and scandals of people living and dead and the folktales kept alive by word of mouth from one generation to the next.<sup>1</sup>

Where writing is unknown, young people have nowhere to turn but to their elders for knowledge of how crises were handled in the past, for tribal origin-tales, even for their own personal family histories, and older people derive honor from this crucial function. In literate societies, however, books, microfiche and other technologies replace human memory, and elders' stories are apt to be dismissed with an impatient "Oh, Gramps! We've heard all that before." An economic force—writing technology—thus helps account for a difference in ideational culture.

In reality, of course, no single factor like literacy can account for all the many forms that human aging has assumed across time and space. We know, for example, that some literate societies still hold the aged in higher esteem than is common in modern America. Stuart Ewen in *Captains of Consciousness*<sup>2</sup> shows that early attitudes in our own nation were far