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Editorial

Health and Socio-Economics of the Elderly

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Aging is reviewed by a variety of disciplines; demographers, sociologists, economists, health scientists, and politicians. However, there are still great disputes over aging because of its economic roles, and health expenditures. Several questions about aging should be answered. Is aging an illness? Are aged people a burden to community? Is it a threat, or an achievement? (1).

There are opposite views, either clinically or economically developed with regard to these questions, about aged people's health and their health expenditures. Clinical view of aging is determined by dominance of chronic disease. These types of illness, was believed to belong to developed countries, well-to-do class, and aged populations. Today, however, developing countries, working class, and even young generation are suffered from theses illnesses (2). Aged people are neither homogeneous nor suffer similar pattern of illnesses. Moreover, gender and sex affect the health status of men and women differently. Apparently in old ages, socio-economic and gender gaps, are widen because of feminization of elderly and poverty.

Changes in population structure of Iran (fertility decline), together with improvements in human development indices are main reasons for increased life expectancy and aged population. The higher rates of chronic diseases requires more resources to be dealt with, since aged people with chronic disease are constant consumers of health services. This is very important in a context with no systematic social support for elderly particularly aged women.

Some argues that aging helps labor force squeezed, therefore aged populations cannot contribute to economic development. David E Bloom, Canning, and Fink, however, believe that though labor force participation rate (LFPR) over the world is reducing and part of it is attributable to aging population, but because of reduced rates of fertility, labor force is increasing and it is expected that this trend is continued up to 2050. More simply, the ratio of labor force to population over 15 was decreasing since 1960 onward, but the ratio of labor force to whole population has been increasing during the same period. Based on this analysis, aging of population has no immediate economic crisis (3).

Two basic theories analyze aged people and their social networks. The first is disengagement theory which emphasis on the relative isolation of aged people from their social roles and responsibilities, that helps the aged to live the rest of their life without stress and anxiety (4). This approach was criticized. Some believe that isolation from family, work, and social environment, and becoming alone, can itself be a cause of stress and sadness. (5). Moreover, the isolation cannot be generalized because it is neither natural, nor unavoidable. Further, the theory cannot explain gender and social classes conflicts (4).

The second theory is called activity theory which emphasizes on barriers that society provides for social interactions. Ignoring specific aspects of aging psychological changes seems to be the major deficit of this theory. There are also political economy, feminist, and modernization perspectives to aged. Political economy emphasis on the role of governments on social relations, and deny the homogeneity of aged population. Feminists centralize gender roles on the process of aging and believe that aged women are discriminated more than their male and younger women counterparts because of lower socio-economic status. Modernization theory attributes marginalization, loneliness, and dependency of aged people to changes on the methods of production, expansion of urbanization, and industrialization of the world community (4).

Sahaf, Shirazikhah et al.; by using WHO and national census data, demonstrate gender inequalities with regard to illness and social life. In terms of coronary heart disease, illiteracy, psycho-emotional problems, loneliness, living in nursing homes, women demonstrated higher rates than men (6).

What makes aging as a major social problem, is their health maintenance and its costs. Many believe that because of weaknesses associated with aging, the aged are great consumers of expensive health services. Therefore, the more aged, the higher health expenditures and financial difficulties, particularly for developing countries.

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By this view, aged people are considered as economic burden, not productive, and reason for lower rates of investment. Supporters of this view, which is called crises theory, emphasise on the growing costs of health care for the aged (7).

Another view considers the effect of aging on health expenditures very limited and manageable. This perspective manageable theories introduces ageing only as one of the components relevant to heath expenditures increase (7). Pro's of this approach considers macro demographic-economic variables as population projection, rates of LFPR, investment, taxes, and savings, together with roles of supply and demand. They conclude that higher health expenditures of aged people are manageable provided that there is a moderate economic growth. Moreover, they argue that generalization of findings from higher health expenditure of an old person to a wide group of population is a fallacy composition.

Tomas Getzen believes that aging has no significant relation with costs and health expenditures, because limited budget in national level for health means that health care expenditures is a function of gross national product growth and political decisions rather than ill health of the aged (7). For example, O'Connell's study about health expenditures among 21 Economic Co-operation and Development countries during 1975 to 1990, demonstrated that aging of population did not increase per capita health care expenditures among these countries. Mc Daniel study's, in 1987 in Canada displayed the same result. His findings demonstrated that in the period of 1961-1980, Canada hospitals' expenditures increased %14.9 while age structure of population remained unchanged. Some other studies have looked far beyond the relation between age and health costs and concluded that health expenditures are significantly related to last years of life or years close to death (7). In analysis of health expenditures of Medicare in U.S., Young and his colleagues found that "time to death" and "age increase" are strongest factors in increasing inpatient and outpatient costs respectively. Demand for long-term care is affected by price, home services price, non-market long-term services available and elderly's income (8).

Heterogeneity of old population, together with complexity of their health, health expenditures and social life, requires more careful approaches, particularly in studying their quality of life.

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