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AGING POPULATION – HEALTH INSURANCE OR CHALLENGE OF AGING FOR SOCIAL SECURITY

Abstract: There are funded biological, physiological and medical knowledge and understanding on age and aging as a natural process, but very different personal and experiential judgments and understanding, and different social and public perception. However, the "encounter" with age is inevitable.

Life that the elderly now have in organized and regulated societies is very different from the lifestyle they had one and a half century ago. That is a quality lifestyle that involves various activities, learning and concerns, carrying at the same time a new type of pathology. Based on the UK data, one half of the hospitalized patients relates to elderly people Aging population, and the extension of human life – sets a new kind of challenge for the physicians and patients, and the society as a whole. The question is how modern medicine and the health care system respond to this kind of challenge.

The question is whether elderly patients have an equal treatment in the existing health protection system, whether they receive the best possible care for their age and whether they are discriminated against in comparison with the other age groups.

Examples of discrimination based exclusively on age, namely age discrimination, in English speaking world known as "ageism" are present and visible in almost all civilizations.

British charity organization "Age Concern" has publicly addressed this issue on the basis of certain indicators and data provided and, inter alia, surveys conducted among primary care physicians. As the key reasons for this situation the following facts have been stated: health workers are not sufficiently educated in the field of geriatrics in order to be able to provide adequate care to elderly patients, elderly people are less likely to be included in the preventive programs or to be subjected to numerous diagnostic tests, they are often deprived of numerous treatments and are deliberately excluded from the new drug testing process.

Discrimination against older people is not only a part of the health system, but is also widely entrenched in the social environment, intergenerational relations, and in modern society in general. Elderly people are in the center of all national policies on social protection. Therefore, the Second World Assembly on Ageing in Madrid organized by the United Nations in 2002 was an important event for the world social insurance. Much has been done in terms of infrastructure, health programs and certainly in terms of social protection of the

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elderly. In majority of countries, more than half of the available social budget is dedicated to pensions, which has enabled the economically developed societies to reduce poverty of the elderly, allowing the younger members of society to think about their old age and express intergenerational solidarity. The aim of this paper is to give a more comprehensive and detailed problems of discrimination, but also to present social programs and health care from which the international community has tried to eliminate discriminatory attitude and improve, develop and enrich the quality of life of the elderly population. Based on the report on the activities and operations of the Institute for Health Insurance of the Sarajevo Canton for 2012 there were 421,962 registered insured persons of which 98,346 were pensioners.

Within the structure of the insured persons, those over 65 make 17,2%.

On the question "When does the old age begin" professor of geriatric answered "The older the man is the later it starts".

Key words: *ageism, health care for the elderly, welfare*

INTRODUCTION

The progress of science and medicine influences the extension of human life span. That puts a new challenge before physicians and patients. Nowadays, with the expected duration of human life it is considered that the average woman who has entered menopause still has one-third of lifetime ahead. That also leads to lifestyle changes and the need that the so called *third life stage*, often referred to as the autumn of life, is adequately accomplished. At the same time, the way of life of the elderly nowadays significantly differs from the way of life they had one and a half centuries ago. That is an active lifestyle that involves various activities, carrying at the same time a new type of pathology. Based on the UK data, one half of the hospitalized patients relates to elderly people. The question is how modern medicine responds to this type of challenge.

Several respectable media, including the BBC, incorporated in their health reports a very sensitive issue, which is also often heard in the USA, specifically: whether elderly patients have an equal treatment in the existing health protection system and whether they receive the best possible care for their age? In the 2000 report almost half of the general practitioners in the UK expressed concern as to whether, when found themselves in the status of an elderly patient, they would be properly treated within the health insurance. One-third of the interviewed primary care physicians expressed doubts as to the quality of care of the elderly hospitalized patients by comparison with the quality of young people health care. Examples of discrimination against elderly patients are reflected in their exclusion from the clinical new drug studies, denial of certain type of treatment or surgery due to "chronological age". Sometimes the decision is made that it is simply not worth doing a diagnostic or therapeutic procedure because the patient is "too old". Exclusion of elderly patients from the new drug test studies is particularly paradoxical given that data reveal that exactly the elderly patients are the main drug consumers.

"Age Concern" is a British humanitarian association, which publicly addressed this issue and carried out a survey among primary care physicians. This organi-

zation claims that "ageism" or discrimination against people based solely on their age is unacceptable, and therefore it fights against unequal treatment of the elderly.

A similar type of statement can be heard from the USA, stating that elderly patients receive second and third-rate care due to inadequate training of health care professionals looking after them, or that due to a discriminatory attitude these people do not deserve the same dedication and quality of life as younger patients. Over 50% of American households with elderly persons have experienced such treatment.

There are situations when people over 60 do not get certain drug prescribed or do not undergo examinations because the health worker considers that it will not improve the patient's condition or fears that the elderly person could not stand particular examination. It often happens that a health worker does not even introduce an elderly patient to the available options, but makes his/her own decision instead. Due to their age, elderly people are often excluded from the malignant disease screening programs.

In 1965 the USA established "Medicare", specialized in providing health insurance to people over 65 and to younger people with severe disabilities. The purpose of establishing Medicare was to enable these two vulnerable age groups access to health care. Unfortunately, the existence of this system does not provide for exclusion of age discrimination regardless of the number of clinical studies and tests which proved its existence at all levels of health care.

As the key reasons for this situation the following facts have been stated: health workers are not sufficiently educated in the field of geriatrics in order to be able to provide adequate care to elderly patients, elderly people are less likely to be included in the preventive programs, they are less likely to be subjected to numerous diagnostic tests, they are often deprived of numerous treatments and are deliberately excluded from the new drug testing process.

Although, nowadays, the elderly present a significant percentage of the population, e. g. 13% of the USA population, it is estimated that by 2030 it will increase to 20%, and that the number of elderly people will grow to 70 million.

Due to their own prejudices towards aging, the elderly themselves have a passive attitude towards their own health, ignoring series of symptoms – such as failing eyesight and hearing, impaired movement, sleep disorder and pain, attributing it to their age and the opinion that it has to be that way.

1. HEALTH AND SOCIAL CARE OF ELDERLY PEOPLE – THE EXPERIENCES OF SOME COUNTRIES

In the UK, "The National Service Framework for Older People" was established within the Ministry of Health, presenting the first organized network with an overall strategy to ensure a full, high-quality integrated networks of health and social care for the elderly. The objective of the program is to promote health, specialized care for the most important pathological conditions, but also to change the public perception of the elderly in terms of preserving their dignity and rights (expected duration of the program is 10 years).

The program includes steps towards improvement of the protection standards, facilitating access to health care, insurance funding, development of an independent network and assisting elderly people to stay healthy. The establishment of this network for the first time publicly acknowledged failures in providing care for the elderly, discrimination against patients on the basis of their age, treatment of the elderly without sufficient dignity and lack the best possible care required for their age.

American Association for Geriatric is a non-profit organization gathering over 6700 health professionals dedicated to improving the quality of health, independence and quality of life of elderly people. The mission of the association is to promote health care, independence and quality of life of elderly people with a vision of the future in which each elderly American will receive high quality and individually focused health care.

Accordingly, the purpose is to increase the number of health workers focused at providing care to elderly people, active lobbying among physicians for a career in the field of geriatrics, raising public awareness of the need for high-quality, interdisciplinary geriatric health care. Particular importance is given to respecting cultural traditions of the elderly.

To which extent is life expectancy extended – do we have old people population and what do we do for it, are they discriminate against?

From a superficial point of view (miraculous statistics), studies conducted in the twentieth century in the United States of America revealed excellent results in extending life expectancy. In 1900 life expectancy was only 45 years. Nowadays, life expectancy for men is 71 year compared with 78 for women. However, if we investigate this case of the life expectancy extension, truly and without propaganda, we will come to an encouraging conclusion that it is almost entirely attributed to reducing infant mortality! Nowadays, there are approximately 580 million chronologically old people in the world, of which about 355 million live in developing countries, which is over 60%. While present seniors make 13% of the American population, it is estimated that by 2030 that percentage will increase to 20%, and that the number of elderly people will grow to 70 million. In Europe, "the *oldest region in the world*", it is expected that in 2020 their share will be 25%. In Croatia, for example, in 2001 the proportion of chronologically old people aged 65 and over was 15,6% in relation to overall population (12,4% for men and 18,6% for women).

2. BOSNIA AND HERZEGOVINA

It is evident that in the overall population of Bosnia and Herzegovina there is a daily increase of people over 65 (in Sarajevo Canton, they make 17,6% of the total population, and in the EU between 13,2 and 17,9% depending on the country).

Overview of specific parameters of the Sarajevo Canton health insurance, including the elderly population

Continuous gerontological monitoring, studying and analysis of the health needs of elderly people in the city of Sarajevo, indicate to growing multiple geriatric morbidity of elderly people and increase of elderly morbidity and mortality largely caused by the mentioned preventable syndromes with declining functional ability of geriatric patients. However, there are many organizational and functional problems in the establishment and operability levels of geriatric health care throughout the country.

In 2011 the number of insured persons in the Sarajevo Canton increased by 4,485 persons.

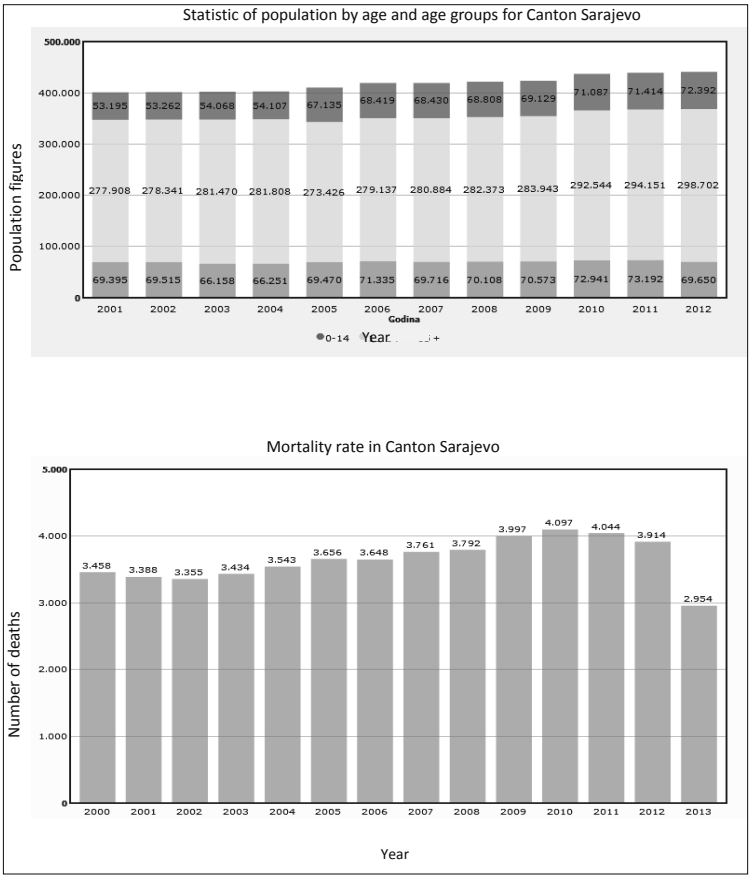

Table 2. Analysing the table of mortality rate per year in Canton Sarajevo it is evident that number of deaths in the period from 2010 to 2013 declined in comparison with a number of persons over 65 year. Analysis of Table 1 shows that in the period from 2001 to 2012 the number of persons increased from 53195 to 72392, which is an increase of persons over 65 for one-third, in the period of a decade.

In relation to the overall population of the Sarajevo Canton, approximately 95% of the population was covered by health insurance.

Out of overall number of insured persons 31% relates to employees, 23% to pensioners and 12% to unemployed persons.

Table 3.

Insurance bases	No. of insured in 2011.	No. of insured in 2012.
Employment	127.376	126.451
Pensioners	94.903	98.346
Unemployed	49.363	52.740
Persons over 65 insured through competent municipal body	71.414	72.392

An interesting solution could be related to an increase in the number of people over 65 years, and an explanation for a large number of pensioners. Possible explanation for a number of persons over 65 could be in the high level health care. Table 1. Funds consumed for health care through the Institute for Health Care of the Sarajevo Canton amounts to EUR 160 million per year, which is the largest number and the highest consumption for health services in Bosnia and Herzegovina, and other explanation is that there is so called drain or brain drain, which means that a part of fertile, young, productive population has left the country in search for a better life. I believe that both these reasons affect the number of persons over 65. With regard to the overall number of pensioners which is for about 26.000 bigger than the number of persons over 65 (Table 3), that can be explained by a large number of disabilities which occurred especially during the war, but also in everyday life and work process.

CONCLUSION

In order to improve the existing situation in the process and system of health care, human relations and treatment of the elderly and to overcome discriminatory prejudices and negatively rooted habits, it is necessary to act at a broader social, educational and economic level. The first step in a multi-disciplinary activism and process would be in the field of medical education (undergraduate, graduate, specialist and continuing – life-cycle), health education and enlightenment; starting from regular, undergraduate educational level, which would enable better knowledge and more information from the field of geriatric medicine in the training of future doctors. In addition to physicians, adequate training and continuing education should also be provided for other medical staff and associates – nurses, psychologists, pharmacologists, social workers, and physical therapists. Human geriatric and gerontology medical principles should be incorporated in the principles of medical ethics and bioethics. The elderly should be equally treated in various segments of social life, and included in different active associations and sections, appropriate training schools and courses. In addition, it is necessary to provide for

all types of health care and health services, and therefore a greater number of elderly people should be included in clinical trials of new drugs, regular preventive screening examinations and programs of economic and psycho-social assistance.

On the question "When does the old age begin" a professor of geriatric answered "The older the man is the later it starts".

REFERENCES

[1] IZVJEŠTAJ o radu i poslovanju Zavoda zdravstvenog osiguranja Kantona Sarajevo za 2011. godinu. www.kzzosa.ba/files/pages/IZVJESTAJ%202012.pd Duraković Z. i suradnici. Gerijatrija – medicina starije dobi. Zagreb: C. T.-Poslovne informacije, d. o. o., 2007.
[2] Bovoar Simon de. Starost (I-II). 2. izd. Beograd: BIGZ; 1987.
[3] The Merck Manual of Geriatrics.
[4] Gavranović M, i suradnici. Klinička gerijatrija: bolest i starost. Sarajevo: Međunarodni centar za mir; 1997.
[5] Gavranović M. Gerijatrija. Sarajevo: Visoka zdravstvena škola; 2007.
[6] Landefeld CS, Palmer RM, Johnson MAG, Johnston CB, Lyons WL, eds. Current Geriatric Diagnosis & Treatment. – New York; Chicago; San Francisco… etc. Lange Medical Books: McGraw-Hill; 2004.
[7] http://www.merck.com/mkgr/mmg/contents.jsp
[8] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4071283.pdf
[9] http://www.americangeriatrics.org/index.shtml
[10] www.hcjz.hr/clanak. php?id=13017&rnd= – 75 k