SHORT REPORT

Elderly people and the public health service: a much desirable marriage

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J Epidemiol Community Health 2003;**57**:525–526

Rocketing healthcare demands are not currently paralleled by available economic resources and the fight against inappropriateness has had only a modest impact. Distribution equilibrium is afforded by various concealed and unconcealed filters to access, including waiting lists, and rationing. Age related rationing (better known as agism), is one of the most widespread forms and is cause for ethical and professional concern.¹ At a time when everyone is verbally in favour of a patient oriented partnership, we decided to consult the public about health resource allocation, addressing the issue from an elderly perspective.² Indeed, evidence on elderly attitudes towards this question is virtually non-existent.

METHODS

We developed a brief questionnaire and organised a household survey in an elderly population, randomly selected from the residents aged 65 or over from central Padua, Italy. Several doctors and psychologists were carefully trained and given a \$50 honorarium for each interview. Each potential participant was contacted in writing and received the interviewers at their home, where final informed consent was obtained. The subjects were asked: "Do you think citizens have the right to all forms of healthcare, even in old age?". The question specifically addressed the issue of equal rights for youth and elderly people in the health domain. Trainees received instructions on containing and orientating answers from scrutinised

Table 1 Base line characteristics by response category*

Variables	No n=11 (2%)	Yes n=483 (96%)	Don't know n=10 (2%)	Total n=504 (100%)	p Value
Gender					0.92
Male	5 (45%)	191 (40%)	4 (40%)	200 (40%)	
Female	6 (56%)	292 (60%)	6 (60%)	304 (60%)	
All	11 (100%)	483 (100%)	10 (100%)	504 (100%)	
Age (y)†	72 (5)	76 (8)	77 (7)	75 (8)	0.23
Schooling (y)†	13 (4)	10 (5)	12 (4)	10 (4)	0.08
MMSE†	29 (2)	27 (3)	27 (7)	27 (4)	0.17
Marital status					0.87
Never married	3 (27%)	82 (17%)	3 (30%)	88 (18%)	
Married	5 (46%)	262 (55%)	4 (40%)	271 (54%)	
Widowed	3 (27%)	128 (27%)	3 (30%)	134 (27%)	
Separated/divorced	0 (0%)	7 (1%)	0 (0%)	7 (1%)	
All‡	11 (100%)	479 (100%)	10 (100%)	500 (100%)	
Cohabitation					0.80
Alone	4 (36%)	116 (24%)	2 (20%)	122 (24%)	
With others	6 (55%)	351 (73%)	8 (80%)	365 (73%)	
In institution	1 (9%)	14 (3%)	0 (0%)	15 (3%)	
All‡	11 (100%)	481 (100%)	10 (100%)	502 (100%)	
Occupation					<0.01
Still occupied	5 (45%)	56 (12%)	1 (10%)	62 (12%)	
Retired	6 (55%)	332 (69%)	8 (80%)	346 (69%)	
Housewife	0 (0%)	94 (19%)	1 (10%)	95 (19%)	
All‡	11 (100%)	482 (100%)	10 (100%)	503 (100%)	
BSI-Depression§	0.37 (0.59)	0.51 (0.60)	0.54 (0.38)	0.50 (0.60)	0.46
Case history					0.40
Arthropathies	1 (9%)	24 (5%)	0	25 (5%)	
Diabetes	0	16 (4%)	0	16 (3%)	
Respiratory disease	0	12 (2%)	0	12 (2%)	
Heart conditions	2 (18%)	63 (13%)	5 (56%)	70 (14%)	
Arterial hypertension	0	60 (12%)	0	60 (12%)	
Gastroenterological disorder	6 (55%)	142 (30%)	2 (22%)	150 (30%)	
Eye disorder	0	10 (2%)	0	10 (2%)	
Endocrinological disorder	0	15 (3%)	0	15 (3%)	
Neurological disorder	0	23 (5%)	0	23 (5%)	
Urological disorder	0	7 (1%)	0	7 (1%)	
No reported disorder	2 (18%)	110 (23%)	2 (22%)	114 (23%)	
All‡	11 (100%)	482 (100%)	9 (100%)	502 (100%)	

*Response to the question: "Do you think citizens have the right to all forms of healthcare, even in old age?"

†Calculated on 504 respondents' means. ‡Some data of the original 504 are missing. §Calculated on 503 respondents' scores.

subjects only in the field of health assistance, skipping all themes of social or political nature (for example, "youth and the elderly are both human beings", "everybody should have enough money to cover basic needs", etc).

Sociodemographic data (age, gender, marital status, household composition, educational level, present and previous occupation) and some case history details were also collected. Folstein's Mini Mental State Examination (MMSE) score was calculated to assess cognitive status. The Brief Symptom Inventory (BSI)-Depression subscale belongs to a subjective evaluation tool formed by nine psychiatric scales deriving from the SCL-90. It has already been used in the Italian community and the indicated cut off is 1.25.³

Statistical analysis was based on the χ^2 technique for nominal and on analysis of variance for continuous variables.

Respondent privacy was carefully observed and analyses were conducted in total anonymity.

RESULTS

The response rate was 76%, totalling 504 respondents (60% women and 40% men). Mean (SD) age was 75 (8). Fifty per cent were married and 69% retired. Mean (SD) MMSE score was 27 (4) and mean (SD) schooling years were 10 (5). The age and gender of the non-respondents did not statistically significantly differ from the respondents.

Four hundred and eighty three (96%) of the elderly participants agreed that a citizen had the right to any form of healthcare, even in old age, 11 (2%) did not agree, and 10 (2%) were unsure.

Table 1 shows the various characteristics of the interviewed population by response category. Measured variables did not exhibit statistical significance, apart from occupation.

COMMENT

Our question returned a general consensus by which the elderly population expressed the universal right to healthcare access. The main limitation to this study seems to be response predictability, but then answers may be considered inherent in the questions of any questionnaire. The reliability of this elderly verdict is, however, supported by the scientific accuracy of the survey, the clarity of the question, and the substantial lack

of influence by studied variables. For the moment, Italy has a rather generous pension programme, longevity index among the highest in the world, as well as a ratio elderly/youth that clearly underlines the increasing aging of the general population. For these motives, it seems that "third age" people are not prone to accept any third class citizenship. Evidently, the problem of guaranteed levels of community health provision in relation to clinical efficacy and economic viability warrant closer examination. Equally inconsistent, however, is the argument that age is already used as a criterion for refusing treatment because it is deemed the right thing to do.⁴ While behaviours cannot be considered ethically acceptable just because they exist, account must also be taken of disagreement by the party most concerned. Recent indications do, however, suggest that future elderly generations will be intolerant of age discrimination and equipped with better powers of advocacy.⁵

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Accepted for publication 6 November 2002

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