Healthy Aging: The Elderly's Achievement

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The aging population is increasing in number in western countries. Aging is associated with higher morbidity, which leads to functional dependency. Functional dependency itself has an impact on morbidity. The demographic changes resulting from the growing number of elderly have a special implication for the health system. There are increased needs for acute care specific to aging and disease, for chronic care, for those who remain functionally dependent, and for sub-acute care for those in the transition phase from acute care to either full cure or dependency.

In their article in this issue of *IMAJ*, Clarfield et al. [1] present the patterns of disability and morbidity in different cohorts of elderly in Israel and compare them to the situation in other western countries. These data are of tremendous importance for defining the burden on the health system for acute and chronic care, both of which have direct economic implications. But aging *per se* is not the reason for the increased costs, as derived from the National Mortality Follow-Back surveys [2]; rather, the independent factor defining the length of treatment in long-term care is not age but the burden of disease. Indeed, Dixon et al. [3] recently demonstrated that acute admissions and length of stay in 253,788 in-hospital deaths in the United Kingdom were not influenced by the age of the patients. Thus, the burden of the elderly on healthcare is derived from the increase in their total number and not from special needs due to their age. Fries's theory in 1980 of the trend of change of the survival curve toward a rectangular curve [4] was reinforced by Vita et al. [5] who showed the impact of risk factors for disease on independent life prolongation.

The role of socioeconomic status in the determination of life expectancy is well established. It was measured either as education level in the United States or social class in the UK [6,7]. The effect of income, on a national level, on the trend to increase life expectancy with increment in per capita income has also been demonstrated [8].

The social status and economic conditions of the elderly are the results of their efforts during their lifetime. Therefore, for people who reach their golden years the prolongation of life expectancy and the decline in dependency have to be considered as *their* achievement and not that of the present health system. The effect of health risk decrement on dependency as shown by Vita and colleagues [5] is also a result of the health knowledge and behavior of the elderly. The difference between Israel and other countries can be partially explained by the social heterogeneity resulting from immigration to the country from different societies, different cultural backgrounds, different languages, in different periods.

In Israel, tens of thousands of long-term care beds are subsidized by the Government and a similar number by private resources. These facilities are all under the supervision of standards of the Ministry of Health. In Europe and the U.S. in recent years, questions have been raised about the futility of some treatment in long-term care. Moreover, a certain impact of profit ownership of long-term facilities on futile treatment was demonstrated by Mitchel et al. [9]. These data suggest interventional bias as an explanation of the higher institutionalization rate in Israel compared to other countries [10].

The elderly in Israel benefit from the prolongation of their lives with improved function, which can be attributed in part to their socioeconomic conditions and to their health behavior. This is a result of their lifelong efforts in building their career, family, health and social environment. We owe it to them to maintain and honor this achievement.

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