Beyond Medicare Reform: Strategies to Enhance Health and Well-Being in Older Persons

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One of our society’s greatest accomplishments, the dramatic progressive increases in life expectancy, also presents one of its greatest challenges as we struggle to develop effective approaches to the design, delivery and financing of social and health care services for the rapidly increasing numbers of older persons. Much of the current debate regarding health care for the elderly relates to “payment reform” in Medicare, including a variety of valuable initiatives relating to enhancements in quality, reductions in waste and increases in “value”. But these efforts, even if successful, will fall short of creating a system of services that meet the needs of older persons. As geriatricians/gerontologists we and other members of the MacArthur Network on an Aging Society have developed a set of recommendations that go beyond the current Medicare reform discussion which we believe can strengthen our capacity to enhance the well-being of our growing elderly population. In this brief paper we highlight our thoughts regarding three of the critical areas: the health care workforce, social and community supports and efforts to enhance engagement of older persons, and public health and prevention. The background documents regarding the Network’s analysis and complete set of recommendations regarding health care can be found at www.Agingsocietynetwork.org.

Workforce

From the perspective of the competence of the health care workforce, we are ill prepared to meet the demand for health care services of the future elderly population. The United States has two simultaneous major health care workforce challenges. The first is the inadequate numbers of
health care providers available to provide basic primary care services, especially in light of health care reform legislation which will provide health insurance to over 30 million previously uninsured. There is currently broad debate regarding whether the best strategy to enhance our primary care capacity should be to train more primary care providers, rely more on interdisciplinary teams or enable advanced practice nurses to provide core primary care services without direct physician supervision. The latter has been recommended by the Institute of Medicine (2010) but resisted by some physician organizations on the stated grounds that the quality of care may suffer.

A second, and equally serious problem, is the general lack of expertise in geriatric medicine in the U.S. health care workforce, including physicians, nurses, social workers and others. This issue has been addressed in a 2008 report from the US National Academy of Sciences Institute of Medicine (2008) “Retooling for an Aging America. Although evidence shows elderly people benefit from health caregivers who understand the needs of their age group, less than 1% of doctors and nurses have training in geriatric care.

Even fewer physician general practitioners do. A focus on expanding the numbers of geriatricians is critical. Geriatricians are in extremely short supply. As of 2012, there was one geriatrician for every 2,551 Americans 75 or older. Given the projected increase in the number of older Americans, this ratio is expected to drop to one geriatrician for every 3,798 older Americans in 2030 (American Geriatrics Society, 2013). Earlier studies predicted 36,000 additional geriatricians would be needed by 2030. But a more recent study (Peterson, Bazemore, Bragg, Xierali, & Warshaw, 2011, p 701) calls that "impossible and unrealistic" (p 701).
The Institute of Medicine made several specific recommendations, including a strengthened effort to assure that all physicians and nurses, as well as specialists, receive training in the basic principles of geriatric care, including the diagnosis and management of not only so-called non-communicable, chronic diseases that are increasingly common with advanced age, such as diabetes, cancer, heart disease and stroke, but also dementia, frailty, polypharmacy, incontinence and other common geriatric syndromes. The focus must be on both quantity and quality of health care staff; not only having adequate numbers but also assuring their competence in geriatrics.

**Social and Community Support, Care and Engagement**

The health of a population is supported not only by obvious medical and public health efforts, but also by the social supports, networks and community that bind people to one another and prevent social isolation. Social isolation is an important predictor of health. Dis-engagement in late life is a very significant public health problem.

In the United States the family has served as the primary safety net for the social, psychological and financial needs of older persons, while government, in the form of social insurance, medical insurance and community services, has played a supportive but secondary role. Family caregivers are an important source of support for an aging population. Today, informal caregivers—either relatives or friends—care for the vast majority of older adults with disabilities. The estimated economic value of their unpaid contributions was approximately $450 billion in 2009. (Feinberg, Reinhard, Houser, & Choula, 2011). The magnitude of informal caregiving services is such that, if such unpaid care were not available, the costs would
overwhelm our health care system. With increased life expectancy and the arrival, in 2011, of the first of the baby boomers to age 65, the need for home-based care provided by informal caregivers will continue to grow

Important changes in the structure and function of the family are threatening the capacity of the family to serve this traditional safety net role. Simultaneous increases in life expectancy and decreases in fertility are leading to more elders with fewer younger family members to support them. For instance, in 1900 21 % of the US population had living grandparents at birth; in 2000 76 % had living grandparents when they reached age 30. (Gonyea, 2013). Increases in women’s participation in the workforce and the fact that as the oldest old reach into their 90s and beyond, their children are also becoming old and have problems of their own further aggravate the difficulty. It is, of course, important to note that all evidence suggests that families wish to care for their elders; the problem is not intent, but capacity.

The risks for older individuals from these changes in family structure and function are both financial and social. Those who see themselves on the bottom rung of social connectedness are more likely to have poorer health, and shorter lives. As Laura Carstensen (2009) writes in *A Long Bright Future*, these findings suggest that “health isn’t just predicted by how many resources people have, but by how they relate to other people.” (p 101)

Being part of a community, having friends, getting out are all predictors of better health. For older adults, the threat of social isolation grows with time, as friends and spouses die, and life becomes more restricted.
Active productive engagement is associated with better physical health, lower rates of depression, and less use of medical services. (Seeman et al., 1995). As volunteers, older adults can fulfill important social and economic needs while reaping the very real mental and physical health benefits of social contribution. In “Building Communities That Promote Successful Aging,” Fried, Freedman, Endres, and Wasik (1997) and colleagues write that while many older adults have a great deal of time available to them, they are “in the main, marginalized from productivity… even though being able to make a contribution has been described as an essential element of successful aging.( p 216 )

There are many approaches possible for creating societal win-wins that support the contributions that older adults seek to make. For this discussion we highlight social programs that support grandparents with a significant amount of responsibility for their grandchildren both protect the children and ease stress on the grandparents. In addition, these programs can support the caregivers responsible for older adults. Federal policy should both directly support these goals and encourage states to do so as well.

**Prevention and Public Health**

Much of the trend driving health care spending today is the result of an epidemic in chronic conditions, including heart disease, hypertension, and diabetes, which has origins in changing patterns of diet and physical inactivity. Chronic disease has been estimated to account for 75 percent of health system costs, and more than two-thirds of Medicare beneficiaries in 2008 had at least two chronic conditions. (Centers for Medicare & Medicaid Services, 2010). Many of these conditions can be prevented or the disease progressions slowed through intensive lifestyle interventions. The results of research into the most effective prevention and screening tools for
these conditions, specifically in older individuals, should inform prevention efforts and the coverage and cost-sharing associated with their use.

Health economist Dana Goldman, a member of the MacArthur Aging Society Network, has studied the value of investments in longer lives of better quality of preventing disease in the first place, rather than treating it later. (Goldman et al., 2009). He examined, for example, the costs and benefits of preventing cardiovascular risk factors such as diabetes, hypertension, obesity, and smoking and finds that prevention—even at older ages—has great social value, and would be cost-effective if the right interventions are adopted.

Goldman and his colleagues found, for example, that a person age 51 or 52 who was effectively treated for diabetes would add 3.1 years and 1.6 quality-adjusted years to life and would save $34,483 in lifetime medical expenses. Quality-adjusted years are defined as years with minimal impediments to mobility and daily activities, as well as minimal pain and depression. Results were similar, though with smaller effects, for other conditions. The bottom line is that these chronic diseases could be prevented and could add significantly to quality of life without increasing average lifetime medical spending.

The creation of the Prevention and Public Health Fund by the Affordable Care Act was a first step toward this goal. The Fund, according to HHS.gov/healthcare, is “an unprecedented investment in promoting wellness, preventing disease, and protecting against public health emergencies.” (U.S. Department of Health and Human Services, 2013, para 1) The Fund helps the states tackle and prevent the leading causes of death and root causes of
costly, preventable chronic disease; detect and respond rapidly to health security threats; and prevent accidents and injuries. In addition, the Affordable Care Act creates a National Prevention, Health Promotion, and Public Health Council, composed of senior officials across the government, to elevate and coordinate prevention activities and design a focused strategy across Departments to promote the nation’s health.

Unfortunately, ongoing use of funds from the Prevention and Public Health Fund in order to offset spending in other areas threatens to undermine the preventive capacity of the entire health system. This is exacerbated by the fact that, although the fund was intended to supplement, not supplant, existing public health funding, this has not necessarily been the case in the face of current budget restrictions.

While the ongoing efforts to improve the effectiveness and efficiency of Medicare are important, and likely necessary to preserve the availability of this landmark program, the intense focus on Medicare reform has been to the neglect of other areas, as described above, which must be advanced if we are to establish a truly effective approach to enhancing wellbeing and managing chronic disease in older persons.

References


