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CHRONIC ILLNESS AND AGING

SECTION 6. POLICY ISSUES RELATED TO AGING AND CHRONIC ILLNESS

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Synopsis

Three policy issues related to aging and chronic disease are highlighted and briefly explored: 1) health care inflation and the sustainability of public financing programs for the care of the chronically ill and disabled, 2) the need to transform the dominant paradigm for the organization and financing of health care as pertains to chronic disease, and 3) the persistence of health care disparities within the aged and chronically ill population despite universal insurance coverage under Medicare. Two of these policy issues, the sustainability of public financing of health care for the chronically ill and disabled and the persistence of health care disparities, could in large part be addressed by the transformation of the health care system's historically dominant "acute care paradigm" to a new structure that is framed by an orientation toward chronic disease management.

Policy Issues

1. Confronting the Sustainability of Public Financing Programs for the Care of the Chronically Ill and Disabled

- Growing health care expenditures: In 2006, the most recent year for which complete data is available, national health care expenditures increased by 6.7% to 2.1 trillion dollars, or 16% of the gross domestic product (Catlin, Hartman, & Heffler, 2008).

Despite all the political and industry rhetoric devoted to the control of health care expenditures, the rate of inflation in health care during 2006 was two times the rate for the economy as a whole (National Coalition for Health Care, 2008). Although the rate of inflation in health care relative to the total economy fluctuates from year to year, it consistently exceeds that for the economy as a whole. As a result, the proportion of gross domestic product (GDP) represented by health care expenditures has grown from 7.2% of the GDP in 1970 to its current rate of 16.0% (Catlin et al., 2008). Notably, this is about twice the proportion of the GDP spent by comparable industrialized democracies

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like France, the United Kingdom, and Canada (Almgren, 2007). The most pronounced effect of this level of health care inflation is the high cost of health care insurance—whether for working-age Americans and their families or for the elderly. Among working-age Americans, in 2006 the employer-based insurance premiums for a family of four increased by 7.2%, to an annual premium cost of nearly $11, 500 (National Coalition for Health Care, 2008).

- Impact of health care inflation on publicly funded programs: Health care inflation has particularly detrimental consequences for the publicly funded programs serving the poor, the disabled, and the elderly.

The principal health insurance fund for the elderly, Medicare Hospital Insurance Trust Fund, is projected to be exhausted by the year 2019 unless health care inflation retreats or taxes for Medicare are sharply increased (Social Security and Medicare Boards of Trustees, 2008). Although funded from general state and federal revenues rather than as an insurance fund, the Medicaid program is also confronting similar sustainability problems. The Medicaid program accounts for nearly one third of publicly funded national health care expenditures, is subject to the same inflationary pressures as Medicare (Catlin et al., 2008), and every year must compete against education, transportation, law enforcement, and defense priorities for a limited pool of tax dollars. Most significantly, Medicaid is the primary funding source for the long-term care of the chronically ill and disabled (Congressional Budget Office [CBO], 1999).

Although multiple factors contribute to the problem of health care inflation and the sustainability health care financing for the elderly and the poor, among them is the reality that a small proportion of the chronically ill (both elderly and non-elderly) account for a very large share of health care expenditures. The more rigorous estimates suggest that since 1970 about 27% of health care expenditures have been concentrated among the sickest 1% of the population—of which about half are elderly (Berk & Monheit, 2001). Notably, a large share of national health care expenditures (49%) are also concentrated among five chronic conditions, three of which (diabetes, hypertension, and heart disease) are closely linked to the process of aging (Druss et al., 2001). Obviously, to the extent that the aged are an ever larger proportion of the total the population, the most economically costly chronic conditions will also increase in prevalence—thus, both further fueling health care inflation and deepening the crisis in the financing of health care.

Two essential policy alternatives are implied by these worrisome trends in health care demands and expenditures. One entails reductions in expenditures through such cost-cutting measures as reductions in payments to providers and in health care benefits to consumers—reductions that are likely to be disproportionately absorbed by the poor, the chronically ill, and the disabled. The second policy alternative, considered in the section that follows, entails a major shift in the national patient care paradigm.

2. Transforming the Dominant Paradigm in the Organization of Health Care and in Health Care Financing

- The Acute Care Paradigm: This paradigm, based on infectious diseases as the major causes of death shaped the health care system models developing during the later half of the 20th century.

The U. S. health care system, in both its financing systems and organization of services, evolved primarily during the first half of the 1900s, an era in which infectious diseases and critical short-term illnesses were dominant among causes of death, rather than chronic diseases (Almgren, 2007). The "acute care paradigm" that arose during this period thus placed emphasis on patient care systems that were effective for the treatment of periodic episodes of care over the life course. In like fashion, the prevailing health insurance models were designed to insure patients against the catastrophic costs of episodes of hospital care, and doctors and insurance companies negotiated fee structures that were based on such discrete units of care as doctor visits and specific medical procedures. Implicit in the acute care paradigm was the inflationary assumption that more intensive medical intervention during any given episode was generally better, an assumption that was reinforced by the economic incentives of the "medical free enterprise" model that shaped the American health care system (Almgren, 2007; Starr, 1982).

- The Emergence of Chronic Disease: The demographic reality is that, as infectious disease retreated as the primary population threat and life expectancy increased, chronic diseases have become the dominant causes of death and disablement and the primary reason people seek medical care (Anderson & Knickman, 2001; Miniño, Heron, Murphy, & Kochankek, 2007).

As noted by Anderson and Knickman (2001), by the year 2020 nearly 160 million Americans will have one or more chronic conditions that in turn will account for 80% of all health care expenditures. Yet, the acute care paradigm continues to reign supreme in the U.S. health care system, with all of its discontinuities and perverse financial incentives for providers. In order for the U.S. health care to turn from collapse toward the path of fiscal sustainability, its primary patient care paradigm must rapidly evolve to a model of chronic disease management (Anderson & Knickman, 2001; Eskildsen, 2007; Master & Eng, 2001; Stuart & Weinrich, 2004; Tilly, Goldenson, & Kasten, 2001).

- Implementing a Chronic Care System: Key policy challenges face researchers, policy makers, and practitioners working to develop effective management programs for chronic conditions and to deliver these programs to those in need.

As suggested by Anderson and Knickman (2001), the shift from a health care system designed around an acute care paradigm to a chronic care system better able to meet the needs of the large share of health care consumers with chronic diseases entails

a number of formidable policy challenges. Included among these are 1) the development of clinical information systems better capable of supporting coordination of care, 2) the improvement of ambulatory care management of chronic conditions that contribute to unnecessary hospitalizations, 3) the alignment of physician and other provider payment mechanisms and incentives with disease management over time rather than episodic treatment of acute symptoms, and 4) a shift from specifically disease-focused interventions to interventions that are tied to functional impairments and that integrate informal and formal support systems with medical case management (Anderson & Knickman, 2001).

- Restructuring health care benefits to address a chronic disease management model may be the most essential and difficult of the challenges.

Of all of these challenges, none is more essential or more difficult than restructuring the Medicare program's benefits and financial structures to better accommodate a chronic disease management model (Master & Eng, 2001; Williams, 2003). Under the current Medicare structure, all forms of provider care must fit within a very narrow definition of medical services to be reimbursed, a definition of care that excludes the kinds of chronic disease management services and long-term care services that are better aligned with the de facto prevalence of chronic diseases and disability among the elderly (Kane, Kane, & Ladd, 1998; O'Shaughnessy, Lyke, & Storey, 2002).

In fact it is Medicaid, the program that was originally designed as a means-tested health care financing program for the poor, that has become the primary means of funding the kinds of long-term care services that are essential to the holistic management of chronic disease. This structural fragmentation of public funding between the Medicare and Medicaid programs is replicated in the structural fragmentation of health care services—to the detriment of chronically ill older adults, all generations of taxpayers, and other segments of the population competing for a limited pool of federal and state fiscal resources. The innovative local and federal community-based care partnerships that are designed to bring coherence, integration, and cost-effectiveness to the care of the most disabled of older adults, like the federal PACE program (see suggested readings for a description of PACE program), are in serious financial jeopardy—both because states are seeking ways to reduce Medicaid expenditures and because the fiscal crisis in Medicare limits the ability of the Congress to provide long-term care financing subsidies to states.

- Impact of structural fragmentation of health care services: Despite compelling evidence of the deleterious effects of health care system fragmentation on population health outcomes, the structural reforms that are required face formidable political obstacles from provider groups having strong economic stakes in the status quo.

Perhaps the most compelling evidence of the effects of this structural fragmentation is evidenced in the extent to which the U. S. lags far behind other affluent democracies in reducing premature deaths from diseases that are amenable to timely and effective medical care, despite the fact that the U.S far exceeds all other affluent democracies in health care system expenditures. For example, over the 5-year period between 1998 and 2003, the U.S. had reduced its age-adjusted death rates from such "amenable to treatment" diseases as treatable cancers, diabetes, and cardiovascular disease by only 4%, whereas the reduction among 18 other nations was a robust 17% (Nolte & McKee, 2008). Notably, the U.S. death rates from these "amenable to treatment" diseases were generally higher to begin with, making the lag in the decline both statistically counter-intuitive and deeply troubling. In sum, although these kinds of findings highlight health care system reform as a national policy imperative, the structural reforms in Medicare and in the organization of health care services that are required face formidable political obstacles from various provider groups that have strong economic interests in protecting the status quo (Vladeck, 1999).

3. Addressing Disparities in the Care of the Chronically Ill and Older Adults: The Role of Race, Class, Gender, and Social Stigma

- Although Medicare health insurance does ensure access to care for all older persons, the access and quality of care received is not necessarily equitable for all.

The Medicare program provides universal health coverage for older Americans. However, having Medicare health insurance does not assure either equity of access to health care or equity in health care quality. Medicare health insurance coverage reduces the disparities in access and quality of health care that are prevalent across all earlier stages of the life course, but disparities by race, ethnicity, social class, and gender persist throughout the oldest age ranges as well (Agency for Health Care Research and Quality [AHRQ]; 2004, 2005).

- Double jeopardy: Impact of aging, social class, race, ethnicity, and gender.

Ageism

Older adults (particularly those with disabling chronic conditions) confront a kind of double jeopardy in their quest for appropriate and equitable care. One form of jeopardy has to do with the ageism and the stigmatization of older adults in the health care system, manifested by such clinical decisions as deferring lifesaving intervention despite otherwise favorable clinical indicators (Hamel et al., 1999) and social policy perspectives that argue for age-based limits on health care (Binstock, 2007).

Social class, race, ethnicity, and gender

The second form of jeopardy arises from the older adult's ascribed characteristics other than age that are also associated with discrimination in the health care system:

social class, race, ethnicity, and gender. A recent multi-dimensional examination of disparities in the U.S. health care system conducted by the Agency for Healthcare Research and Quality, the *2005 National Healthcare Disparities Report*, examined disparities in health care among the elderly by three dimensions: prevention, timeliness of care, and access to care. The findings of this report, based on data from the 2002 Medicare Current Beneficiary Survey (MCBS), showed significant disparities in health care by race, ethnicity, and socioeconomic status across all three dimensions considered. For example, the *risk of colorectal cancer* increases in old age, but if detected early is generally curable. An inexpensive and simple screening tool for the early detection of colorectal cancer is the home fecal occult blood test, which if positive suggests further diagnostic investigation is warranted. However, findings from MCBS show remarkable disparities in this easy form of colorectal screening by race, ethnicity, and income level—despite the fact that all elders sampled by the MCBS were by definition Medicare eligible. It is no surprise that the incidence of late stage colorectal cancer is much higher among those groups that have lower levels of early detection screening (AHRQ, 2005). Similarly, the *2005 National Healthcare Disparities Report* finds that elders who are Hispanic, African American, or low-income are far less likely to have a usual source of medical care and, when seeking care, have longer wait times for their medical appointments (AHRQ, 2005). The summary point, from a policy perspective, is that Medicare's universal health care coverage is insufficient by itself to overcome the deeply embedded disparities in the U.S. Health Care system, and that the eradication of health care disparities throughout the life course must be elevated as a central principle of health care reform.

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Curriculum Resources

Suggested Readings

- GAO—Testimony Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives. Long-Term Care Financing: Growing Demand and Cost of Services Are Straining Federal and State Budgets
  United States Government Accountability Office, Washington, DC.
  Full report available for download at
  http://www.gao.gov/new.items/d05564t.pdf

The Government Accountability Office (GAO) reports are meticulously researched, politically objective, and often the most credible source of information on critical policy issues. This particular report at 20 pages is fairly brief by GAO standards; however, it quite effectively explains and graphically depicts the population health and health care expenditure dynamics undermining the fiscal sustainability of Medicare and Medicaid. The report provides the essential demographic and fiscal context necessary for any discussion of health care policy, as pertains to chronically ill and disabled populations.

- Grabowski, D. C. (2006). The cost-effectiveness of noninstitutional long-term care services: review and synthesis of the most recent evidence. *Medical Care Research Review*, *63*(1), 3-28.

In the Balanced Budget Act of 1997, Congress established the PACE Program (Program of All-Inclusive Care for the Elderly), which integrates Medicare and Medicaid financing in order to provide a comprehensive array of medical and community-based long-term care services for older adults who are at high risk for nursing home placement. This article provides the most recent review of the literature analyzing the outcomes of PACE and similar programs.

- Master, R. J., & Eng, C. (2001). Integrating acute and long-term care for high-cost populations. *Health Affairs*, *20*(6), 161-172.

The transformation of the health care system from an acute care paradigm to one that embraces chronic disease management must be informed by examples of systems of care that test new innovations in the organization, financing, and delivery of care to the chronically ill and disabled. Master and Eng describe the policy history of these initiatives, and then explore the policy lessons learned from programs developed through two general policy models: the Program of All-Inclusive Care for the Elderly (PACE) and the Community Medical Alliance (CMA). Although the programs examined under PACE and CMA are oriented toward different chronic disease populations, all share similar characteristics: in particular, prepaid, risk-adjusted financing; integrated Medicare and Medicaid funding streams; a flexible array of acute and long-term benefits; and integrated delivery systems that tailors benefits and services to individual need. The "lessons learned" from the programs examined highlight both the policy challenges

and opportunities entailed in a shift toward widespread health care system incorporation of a chronic disease management model.

- Stuart, M., & Weinrich, M. (2004). Integrated health system for chronic disease management: lessons learned from France. *Chest, 125*(2), 695-703.

Stuart and Weinrich examine France's approach to the management of a highly prevalent form of chronic disease, Chronic Obstructive Pulmonary Disease (COPD), through regional community-based specialty systems. There are four reasons this article is highly suggested reading. First, COPD is the major cause of respiratory failure, itself the fourth leading cause of death in the U.S. Second, France has been rated number one in overall health care system performance by the World Health Organization despite the fact that France's per capital cost for health care is about half that spent by the U.S. Third, France has lower age-adjusted death rates from chronic diseases and the pace of reducing preventable deaths from chronic diseases exceeds that of the U.S. by a wide margin (Nolte & McKee, 2008). Finally, the comparisons between the U.S. and France are contextualized by recent developments in U.S. health care policy toward the chronically ill and disabled. This article is targeted at a clinical audience rather than health care policy specialist, making it far less technical and cluttered with obscure policy jargon.

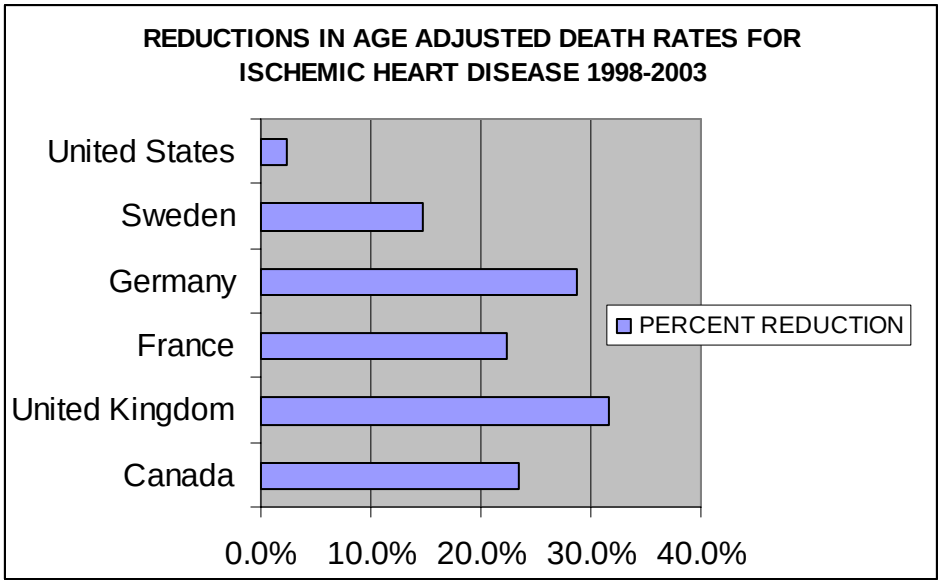
- Agency for Healthcare Research and Quality (AHRQ). Health Care Disparities Reports
  Available for download at:
  http://www.ahrq.gov/qual/measurix.htm

The Agency for Healthcare Research and Quality (AHRQ) is a sub-agency of the U.S. Department of Health and Human Services (HHS) and the lead federal agency for research on health care quality, costs, outcomes, and patient safety. A key research program undertaken in recent years is the investigation of health care disparities within the U.S. health care system, with a special focus on the population groups where disparities in health care are most prevalent or most detrimental, including African Americans, Hispanics, Native Americans, the poor, and the elderly. Since 2003, the AHRQ has published an annual series of National Healthcare Disparities Reports, highlighting the populations affected, the forms of healthcare disparities, and progress towards specific improvements. Each of these annual reports is quite comprehensive, straightforward to interpret, and replete with compelling findings and policy implications.

Class Discussion Exercise

The graph below shows the reductions in deaths from ischemic heart disease among 6 countries during the 5-year period between 1998 and 2003. Ischemic heart disease is a chronic health condition that is quite prevalent in old age and a leading cause of death (Miniño, Heron, Murphy, & Kochankek, 2007). It is also a disease considered highly amenable to timely and effective medical care (Nolte & McKee, 2008). Although U.S. health care spending is about 70% in excess of the average expenditures of the other countries used for comparison (OECD, 2005), it is clear that the U.S. lags considerably behind these other countries in reducing the incidence of preventable deaths due to ischemic heart disease.

Using the Policy Issues section (above) as a reference, identify at least 3 factors within *the dominant paradigm in the American medical care system that might account for some of this lag in the U.S. health care system's effectiveness.*



Data Source: Nolte, E., & McKee, C. M. (2008). Measuring the health of nations: Updating an earlier analysis. *Health Affairs, 27*(1), 58-71, adapted from data displayed in Exhibit 2.