



Policy Brief

FINDINGS FROM THE 16TH PRINCETON CONFERENCE, SPONSORED BY THE COUNCIL ON HEALTH CARE ECONOMICS AND POLICY, MAY 20-21, 2009.

HOW WILL WE MEET THE HEALTH SERVICE NEEDS OF AN AGING AMERICA?

By Jeffrey Sussman, MPH, MA and Stuart Altman, PhD

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The 16th Annual Princeton Conference in May 2009 focused on how we will meet the health care service needs of an aging America. As the country's baby boomers age, the U.S. faces significant challenges in caring for them—and little advanced planning has taken place.

This year's theme was influenced by the 2008 Institute of Medicine report, *Retooling for an Aging America: Building the Health Care Workforce*, which called for fundamental change in the geriatric and long-term care workforce in the U.S. This report predicted that by 2030 the United States will need an additional 3.5 million health care providers—a 35% increase from current levels—just to maintain the current ratio of providers to the total population.

In addition to discussing the workforce needed to care for an aging America, this year's conference also focused on innovative models of care delivery for the elderly, financing long-term care and health services for the aging population, end-of-life care, meeting the needs of aging minorities, and where we go from here.

Like so many challenges in health care, caring for our aging population is not an immediate problem. But it is a looming crisis of immense magnitude. Presented at this conference were several policy options that deserve significant consideration. This policy brief presents findings from the 2009 Princeton Conference and offers conclusions, potential solutions, and next steps.



Dr. David Reuben

“THERE ARE NOT ENOUGH GERIATRICS SPECIALISTS, AND GENERALISTS AND SPECIALISTS ARE UNPREPARED TO CARE FOR OLDER PERSONS.”

SUPPLY AND DEMAND FOR MAJOR HEALTH PROFESSIONS

This session highlighted the shortage that exists—and will only get worse—in health professionals that provide health care for American’s aging population.

Dr. David Reuben of the David Geffen School of Medicine at UCLA shared statistics about the shortage of geriatrics specialists.

Currently, only 1% of physicians specialize in geriatrics compared to 8% who focus on pediatrics. There are just 7,100 geriatricians in the U.S., which is declining, and only 1,600 geriatric psychiatrists.

Part of the reason for this shortage is demand related. Today, 85% of Medicare enrollees are paid on a fee-for-service basis, which promotes higher volume and favors procedures. Because geriatricians do not perform procedures that are highly reimbursed, their chief value to an institution or a practice is through downstream revenues, which frequently are not adequately considered. And part of the shortage is related to supply. Few physicians are attracted to the field of geriatrics due to negative stereotypes of older adults, income that is far below other specialties, inflexible hours, and hard work. In addition, today’s payment system does not compensate physicians for phone calls, emails, patient education, or care coordination, all of which are essential components of care of older persons.

These factors limit physician interest in pursuing geriatrics as a career choice and result in significant gaps in caring for aging Americans.

Fill Rates for Training Positions and Compensation Rates for 2008

	Fill Rate (1 st year)	Median Compensation
Geriatric Medicine	60%	\$179,180
GIM	Not applicable	\$191,198
Rheumatology	95%	\$218,697
Neurology	93%	\$234,505
Nephrology	85%	\$283,226
Gastroenterology	96%	\$449,014

Fill rates from Sarah E. Brotherton; Sylvia I. Etzel, Graduate Medical Education, 2008-2009 *JAMA*. 2009;302(12):1357-1372
 Compensation rates from Medical Group Management Association. Physician Compensation and Production Survey, 2009 Report Based on 2008 Data.

Dr. Reuben summarized the physician-focused recommendations of the IOM’s 2008 *Retooling for an Aging America* report. They are:

- **Increase Competence.** All licensure, certification, and maintenance of certification for health care professionals should include demonstration of competence in the care of older adults as a criterion.
- **Expand Training Sites.** Hospitals should encourage the training of residents in all care settings where older adults receive care, including nursing homes, assisted living facilities, and patients’ homes.
- **Increase Geriatrics Recruitment/Retention.** Public and private payers should provide financial incentives to increase the number of geriatric specialists in all health professions.

Dr. Terry Fulmer, Professor and Dean of the College of Nursing, New York



Dr. Terry Fulmer

“ONE REMEDY FOR THE INADEQUATE NUMBER OF PRIMARY CARE PROVIDERS IS TO PLACE NURSE PRACTITIONERS INTO THAT ROLE.”

University, concurred that there is a shortage of physicians to meet the needs of aging Americans. Not only is there a shortage of geriatricians, there is also a dearth of primary care physicians. She suggested without fundamental change, there will be a failure of the U.S. healthcare system.

Dr. Fulmer recommends changing practice patterns by delegating some aspects of the care currently performed by physicians to other healthcare professionals, such as nurse practitioners. This idea is supported by:

- **Historical precedent.** Nurse practitioners (NPs), registered nurses who are educated to provide primary care to patients, originated in the 1960s in response to a physician shortage.
- **Existing reality.** There are currently more than 150,000 NPs who conducted more than 600 million patient visits in 2007/08 and wrote almost 500 million prescriptions.
- **An explosion of knowledge.** The explosion of knowledge and technological advances make it possible to more effectively deploy NPs to deliver many health services for an aging population.

Expanding the scope of practice for NPs to match their competence could increase access, improve quality, and decrease costs. Major impediments are existing scope of practice laws, financing and reimbursement mechanisms, malpractice insurance, and outdated practice models. These impediments are affected by dominant provider groups who react with protectionism to prevent change. Bringing about change requires overcoming this protectionism, adopting a uniform scope of practice law, and

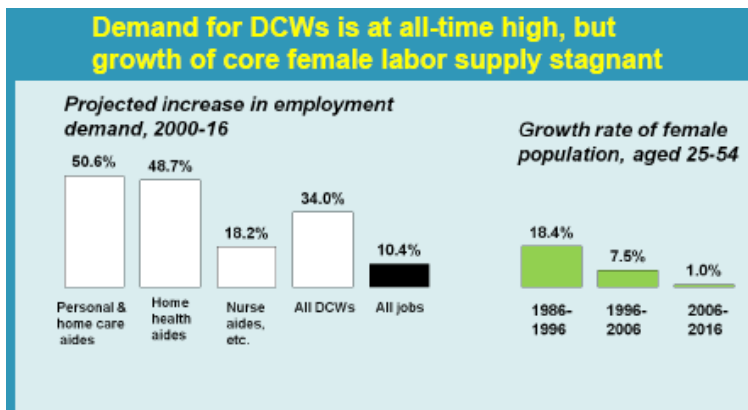
increasing the number of NP programs to address the growing demand for care.

Dr. Peter Kemper, professor at Pennsylvania State University, pointed out that there are two related but distinctive types of aging occurring. The first is the aging of the individual, and the second is the aging of the overall population. Each will come with its own set of potential problems and solutions, though the former is likely to be responsive to individual level policies, while the latter to public health and community polices. Dr. Kemper then suggested that we need to view long-term care and quality of life as topics as worthy as acute care and quality of care. Moreover, care itself must be seen as an equal to cure in terms of importance, something not often seen in the policy or clinical worlds.

Once this is accomplished, there are additional steps that should be taken. These include education about the differences between hospice and end-of-life care, the inclusion of direct care workers as respected professionals, the acknowledgement that long-term care is much more than nursing home care, and the creation of a better trained direct care workforce.

Steven Dawson, the president of PHI, focused on the important role that direct-care workers (DCWs) play in providing health services for aging Americans. DCWs include home health aides, personal and home care aides, and nursing aides, orderlies, and attendants. PHI estimates that between 2006 and 2016, the number of DCW jobs will increase by more than 1 million, making these among the fastest-growing occupations in the U.S.

However, while the demand for DCWs is at an all-time high, there is a challenge in recruiting enough individuals for these positions. The projected increase in demand for DCWs from 2000 to 2016 is 34%, but the population growth among 25- to 54-year-old females—the segment of the population that fills most DCW jobs—is projected to grow just 1%. And, the real wages for home care workers have actually declined over the past decade. This combination of factors creates the risk that the supply of DCWs will fall short of the demand.



Source: Steven L. Dawson, PHI

CURRENT TRENDS AND INNOVATIVE METHODS OF CARE DELIVERY

This panel reviewed research about models of caring for the elderly, particularly those with chronic conditions. Panelists discussed the challenges that are faced, models that work, and possible policy options.

Dr. Chad Boulton, a professor at Johns Hopkins Bloomberg School of Public Health, has conducted a literature review to identify successful, diffusible models of caring for older adults with chronic conditions. The factors in being able to “diffuse” a successful model include: a

model’s effectiveness; its consistency with the prevailing culture; and its simplicity, observability, and trialability.

This review, which looked for models that improved health care quality or outcomes, improved health care efficiency, and were diffusible, found the following successful models:

- Interdisciplinary primary care
- Adjuncts to primary care
- Transitional care
- Dyadic institutional long-term care

Policy options that could help expand the use and diffusion of effective models include adjusting fee-for-service Medicare to include payment for: medical homes; providers who supplement primary care (such as nurses, rehab therapists, and pharmacists); and organizations that provide nurse-based transitional care. However, in Dr. Boulton’s view, “Tinkering with Medicare won’t do it.” This won’t be enough to transform chronic care in America. Bold new payment policies are needed to support and diffuse effective models, and improve the quality, outcomes, and efficiency of health care for older Americans.

Transforming care in an aging society was also the focus of **Dr. Molly Joel Coyne**, founder and CEO of Health Technology Center. She observed that important systemic changes to transform health care are picking up momentum. There have been care process improvements, changes in reimbursement (such as payment for episodes of care, pay-for-performance, and modified capitation), and investments in IT. Also, the functions and coordination required for



Dr. Chad Boulton

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successful management of chronic diseases have been identified.

Yet, major challenges exist in providing affordable, feasible, and successful chronic care. Among these challenges are workforce issues, complexity, diversity, getting patients to change behaviors, quality and safety, and business models.

Dr. Coye concluded that a critical aspect in solving these challenges is utilization of transformational technologies, which have the potential to disrupt and fundamentally change the health care system. Transformative technologies are disruptive because they can change care processes and challenge existing business models.

Disruptive technology can also make innovations more feasible and affordable at scale. Examples of transformational technologies are remote patient management, medication management, caregiver communication, remote training, and social networking.

Remote patient management can transform chronic care by enabling regular monitoring and early intervention. It can enable the sharing of data and the integration of care. Through remote patient management, providers can build trust with patients and provide coaching to encourage behavior change. Workforce productivity can increase as work can be shifted to lower-level workers. Early trials among patients with chronic diseases show extremely positive results in increasing self-management and decreasing the utilization of health care services.

An example of a nursing-driven model that is working well in caring for the elderly is the LIFE (Living Independently For Elders) model. This model was established in 1998 by the University of Pennsylvania School of Nursing.

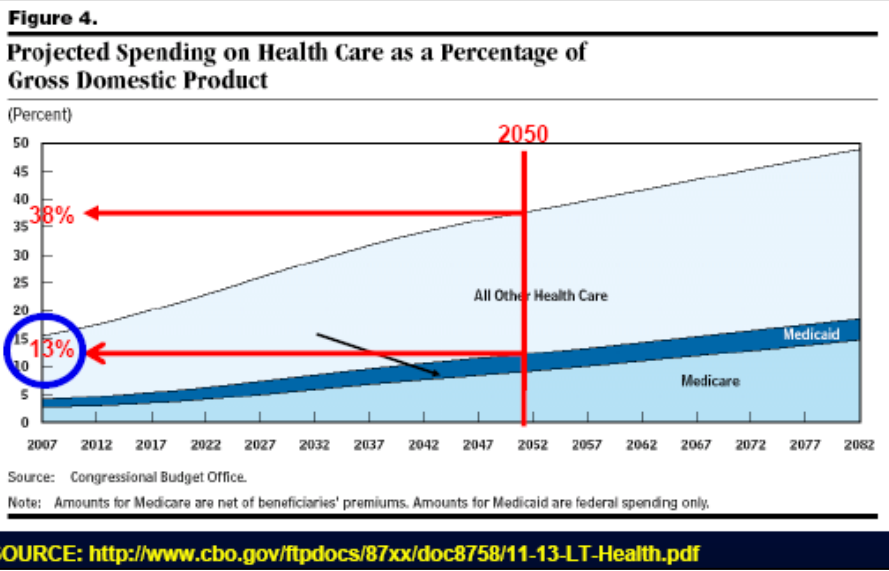
An integrated team coordinates all aspects of a patient’s care including acute hospital care, primary care, rehabilitation, skilled nursing facility care, in-home services, pharmacy services, specialty services (like dentistry and podiatry), and more. The team includes nurse practitioners, a geropsychiatric nurse, a home health nurse practitioner, home care nurses, and day center triage nurses.

Along with effusive testimonials about the benefits of this program and the ability to keep living independently, participants have higher rates of community survival, lower hospital readmission rates, and 15% to 20% lower Medicaid costs.

FINANCING HEALTH CARE SERVICES: CURRENT AND FUTURE TRENDS

This session addressed the high rate of cost growth in the health care sector. The majority of elderly individuals in the U.S. ultimately rely on Medicare and Medicaid for health and long-term care coverage.

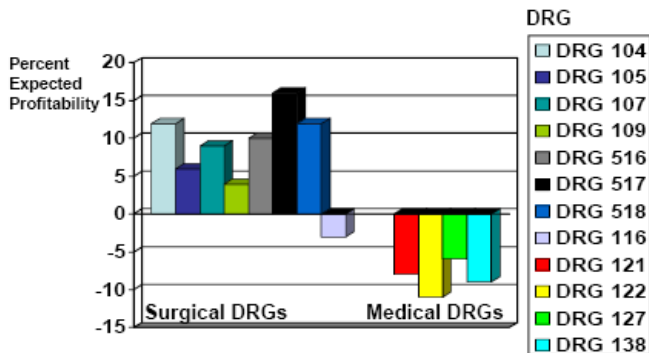
The panelists cited data from the Congressional Budget Office (CBO) that projects health care spending to represent 38% of GDP in 2050 and 50% of GDP in 2082.



In looking at the causes for the growth in health care spending, **Dr. David Grabowski** from Harvard Medical School and **Dr. William Scanlon**, a senior policy advisor with Health Policy R&D, identified the following factors:

- **Silos.** They cause a lack of coordination, resulting in high and unnecessary costs. High rates of expensive and often preventable rehospitalizations are an example.
- **Prices.** Higher health spending in the U.S. with lower use of health services means that U.S. prices are higher. Professor Reinhardt termed Medicare the “big dumb price fixer.” An example: the way Medicare used to set prices resulted in high levels of provider profitability for surgical

Relative Profitability across DRGs
Cardiac DRGs

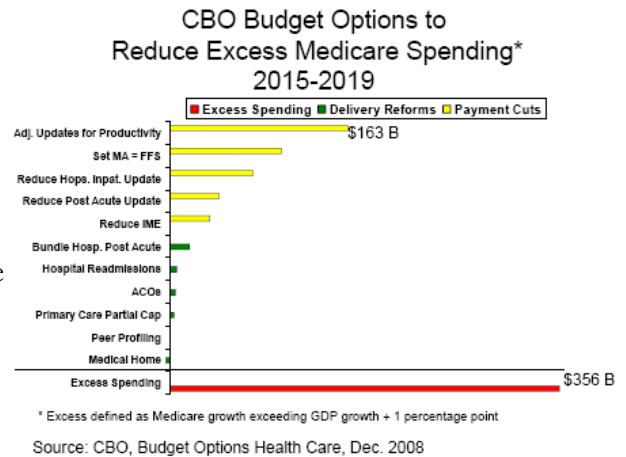


cardiac DRGs and negative profitability for medical cardiac DRGs.

- **Variation.** The panelists all gave examples of the huge spending variations—across Medicare, within the Federal Employees Health Benefits Program, and among private insurers, which are supposedly smart negotiators.

Among the ideas mentioned to reform the health care system were:

- **Payment cuts.** The CBO has listed several potential payment cuts which include adjusting the planned updates for productivity, setting Medicare Advantage rates equal to fee for service, and reducing hospital inpatient and post-acute updates.



- **Getting relative prices right.** Dr. Scanlon offered this as a cost containment tool. Doing so would require getting prices right by service, patient need, and market. Setting prices for bundles/episodes requires data; making well-defined bundles work involving multiple providers will require cooperation among those providers. The way prices have been set for cardiac DRGs (failure to use



Dr. Uwe Reinhardt

“BUNDLED PAYMENTS ARE DESIGNED TO TRIGGER CLINICAL INTEGRATION OF THE DELIVERY OF CARE ACROSS AMBULATORY AND INPATIENTS SITES. BUT THAT IMPLIES A REDISTRIBUTION OF CHERISHED PROFESSIONAL AND ECONOMIC PRIVILEGE. . . . HOW EASY WOULD THAT BE?”

existing data) and home health episode (failure to collect sufficient data) payments offer cautionary tales.

- **A new paradigm for service production.** Dr. Scanlon sees a potential new paradigm that could flatten the cost curve. It would focus on personnel and technology. Personnel would engage in task-focused occupations, would be trained to be fully, but minimally, qualified; would be technology dependent; and would use triaging. Technology would be displace personnel and would enable decision support and decision making.
- **Mixing bundled and cost-based payments.** Dr. Grabowski suggested a “mixed system” in which a hospital episode is paid partly prospectively (a bundle) and partly cost-based (outside the bundle). Bundled payments on their own might address cost shifting and coordination of care, but would have multiple unintended consequences, such as a volume response, selection, stinting, and upcoding. Dr. Grabowski suggested that a mixed system might balance the complexities that exist. (Princeton professor **Uwe Reinhardt** was skeptical whether clinical integration could truly be achieved through bundling.)
- **Other Medicare modifications.** Dr. Scanlon mentioned possible Medicare payment modifications which included SNF payments based on need, not use, and payments for imaging services that are more closely tied to actual costs.

Reinhardt’s proposal. Professor Reinhardt’s proposal had the following components:

- Require that hospitals use the DRG system as a relative value scale for all patients.
- Allow hospitals to set their own conversion ratios.
- Require hospitals to charge the same fees to all payers.
- Start bundling in the RAPs and convalescent care.
- With most of inpatient care bundled in this way, expand the system to embrace more and more of care in other settings.

Professor Reinhardt challenged whether the current financial model is unsustainable. He asserted that the system is economically sustainable, even if it might be politically unsustainable. He presented data showing that from 1965 to 2007 real GDP per capita grew at 2% per year. Conservatively, if real GDP per capita grows just 1.5%, in 2050 it will be \$88,850. Of this, only about \$11,000 would be for Medicare and Medicaid. Professor Reinhardt said, “I take it that by [saying the system is unsustainable] we do not mean ‘economic sustainability’ but ‘political sustainability’; that is, willingness to pay taxes to care for the health care of the elderly.”

HOW DO OTHER COUNTRIES PROVIDE SERVICES TO THEIR AGING POPULATIONS?

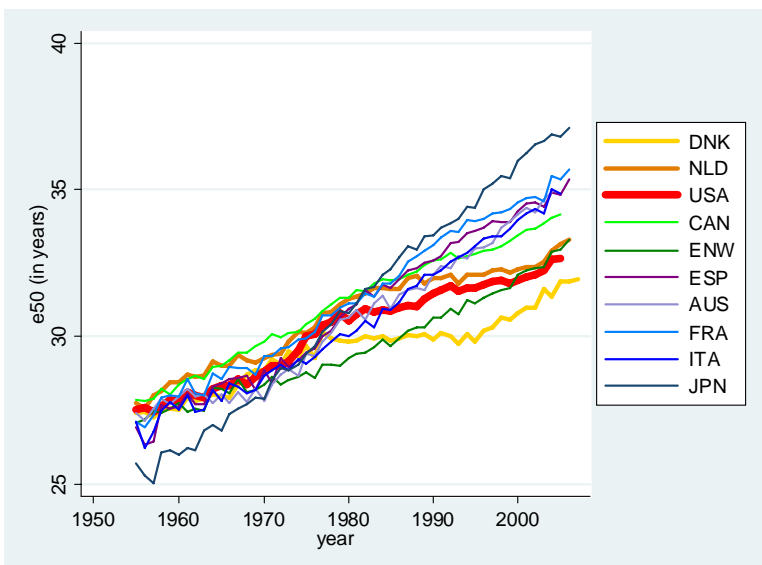
The U.S. is not the only country dealing with the challenges of providing health care services to an aging population. In this session, **Dr. Joshua Wiener**, Senior Fellow and Program Director at RTI International, examined long-term care systems in cross-national perspective and **Dr. John Haaga**, Deputy Director

of the Division of Social and Behavioral Research at the National Institute on Aging, discussed recent research in international aging and priorities for cross-national comparisons.

LTC is becoming more prominent on the public agenda in other countries, largely due to a higher percentage of the population needing LTC services. And also, an aging population need not place an impossible burden on society. For example, several European countries and Japan are well ahead of the U.S. in the process of population aging, yet expenditures in the health sector are well below those in the United States.

Measured against other developed countries studied (Germany, Ireland, Netherlands, Sweden and the U.K.), the proportion of the U.S. population that is 80 years of age or older is comparable at 3.3%. The percent of the U.S. population that is age 80 and older is expected to be 6.9% in 2040, which is below many other industrialized countries.

Dr. Haaga discussed this chart by Samuel Preston to show that the U.S. has fallen behind many other countries in life expectancy at older ages:



In general, the financing for LTC is separate from traditional health care financing. Other than Sweden, which spends almost 3% of its GDP on public LTC spending, the other countries spend from 0.52% (Ireland) to 1.34% (Netherlands) of GDP on public LTC expenditures in 2000. The U.S. is in the middle of the pack at 0.74%. In general, countries with an older population spend more, while those with a younger population spend less. Based on aging populations, in 2050, total LTC spending (public and private) is expected to account for an additional 1% to 1.5% of GDP in the U.S. and most OECD countries.

There is significant variation in how LTC is financed and provided.

- **Who pays?** Financing for long-term care is dominated by public spending in almost all countries. Private LTC insurance is small. Several countries provide universal LTC coverage; but some have a means-tested system of financing long-term care.
- **Who provides?** In some countries (such as the Nordic countries), LTC is primarily a publicly provided service, while in other countries (like the U.K.), LTC is primarily provided privately.
- **Level of government.** Countries such as Germany rely on a uniform national program across the entire country. In contrast, countries like the U.S., the U.K., and Sweden rely on sub-national programs. Having LTC provided or overseen more locally makes it arguably less rigid and more responsive to local norms, circumstances, and values, but at the cost of horizontal equity. In countries where



Dr. Joshua Wiener

“A HIGHER PUBLIC ROLE [IN LTC] DOES NOT MEAN EXPLODING PUBLIC EXPENDITURES.”

LTC is provided by private parties, the government is increasingly involved in monitoring.

In addition to institutional care, almost all countries are promoting formal home care services and looking for ways to support informal caregivers. Countries are trying to create more balanced delivery systems by spending more on home care or reallocating funds from institutional care.

This analysis and the experience of other countries with more aged populations shows that it is possible to serve these populations, with the public sector playing a key role, without exploding public expenditures. Additional studies are needed to review the care trajectories of the frail elderly with multiple comorbidities, descriptive epidemiology of dementia, and end-of-life and palliative care.

CURE AND CARE IN THE LAST YEARS OF LIFE

This panel focused on palliative care and offered ideas and policy suggestions to improve the care for those with serious and advanced illness, while decreasing the costs.

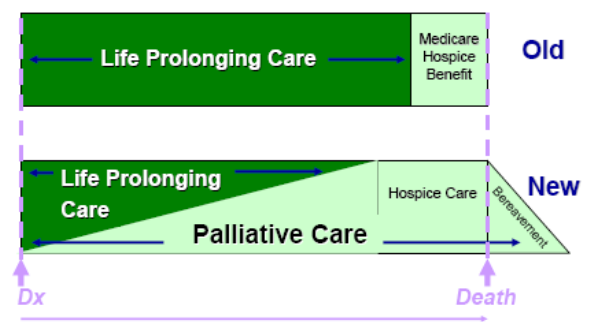
Dr. Diane Meier, Director of the Hertzberg Palliative Care Institute and the Center for Advanced Palliative Care, provided an overview of palliative care and its benefits, and offered policy considerations.

As of June 2008, CMS adopted a new definition of palliative care: “Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing

physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.”

Hospice provides palliative care for those in their last months or weeks of life, but non-hospice palliative care can be appropriate at any point in a serious illness. Palliative care can be provided at the same time as life-prolonging treatment.

Conceptual Shift for Palliative Care



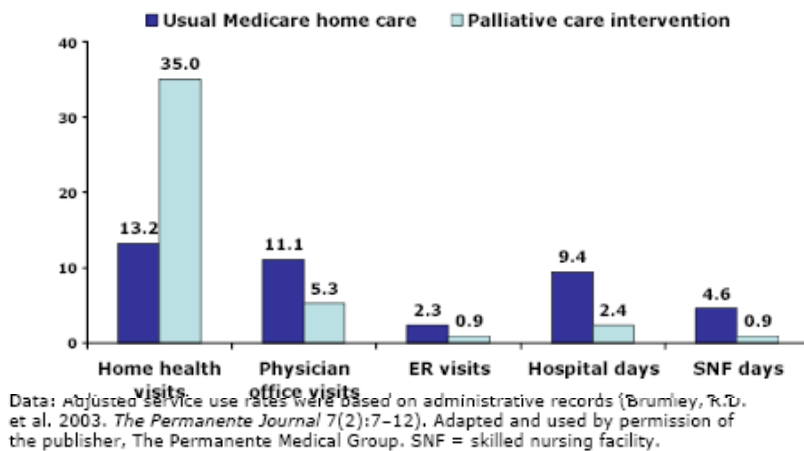
Palliative care:

- **Improves patient care.** Across multiple measures, satisfaction is higher and symptom burden lower among those who participate in palliative care.
- **Reduces costs.** Data demonstrate cost avoidance. This is because talking with physicians and families about matching treatments to achievable patient goals tends to lead to less aggressive, more conservative care, which costs less. Also, care is provided in more appropriate, often lower-cost settings. For example, one study of patients enrolled in a home palliative care intervention showed that home health visits increased while physician office visits, ER visits, hospital days, and SNF days all declined significantly. Another study

showed that costs go down significantly and consistently within 48 hours of a palliative care consultation.

Palliative Care at Home for the Chronically Ill Markedly Reduces Utilization

Service Use Among Patients Who Died from Heart Failure, Chronic Obstructive Pulmonary Disease, or Cancer While Enrolled in a Palliative Care Intervention or Receiving Usual Care, 1999–2000



As Dr. Meier said, “End of life conversations demonstrably improve quality and reduce costs.”

However, the access to palliative care is highly variable. Only 33% of hospitals have palliative care. Hospitals that lack such programs tend to be smaller, in the South, for-profit hospitals, and public or the sole community provider. One limiting factor is the workforce. Currently 23 states and Washington, D.C., have no access to graduate medical education in palliative care. As a result, while there is one oncologist for every 145 patients who are newly diagnosed with cancer and one cardiologist for every 71 heart attack victims, there is just one palliative medicine specialist for every 31,000 people with serious advanced illness.

Ensuring that all seriously ill Americans have access to quality palliative care requires assuring access to care

by building a workforce and financially incenting providers to deliver palliative care. Assuring the quality of palliative care requires populating medical schools with trained faculty, having hospital accreditation, and allocating funds for research.

Dr. Linda Emanuel, a professor at the Buehler Center on Aging and at the Northwestern University Feinberg School of Medicine, offered specific ideas on changing end-of-life care. Her ideas are for “hybrids.”

1. The first hybrid focuses on combining education and training with dissemination and implementation. Specifically, the idea is to combine EPEC (Education in Palliative and End-of-Life Care) with TIPS (Tailored Implementation of Practice Standards). EPEC focuses on educating and training professionals and end users to deliver palliative care. TIPS provides a model for implementing evidence-based practice standards in a flexible way.
2. The second hybrid combines medicine and economics to create a cost-effective policy. One way of looking at the benefits of palliative care is assessing if it provides some form of household “economic resilience,” preventing households from spiraling into poverty and ill health. For example, are there economic benefits to the household and society from investing in family caregiver training—something that palliative care does anyway when it trains caregivers in how to care for their family member? Could this lead to potential employment options?



Dr. Diane Meier

“PALLIATIVE CARE IMPROVES PATIENT CARE . . . REDUCES COSTS . . . AND END OF LIFE CONVERSATIONS DEMONSTRABLY IMPROVE QUALITY AND REDUCE COSTS.”

Dr. Joanne Lynn suggested that we need to change the methods for improving end-of-life care. This means quick legislative fixes are not the answer but rather an overall strategy is required. This should be developed by a coalition, or a political movement comprised of family caregivers, advocates, service workers, and businesses, among others.

The ideas shared in this session all have the potential to improve the quality of care and the quality of life while reducing costs.

HEALTH SERVICE NEEDS OF AGING MINORITIES

This session focused on the situation for aging minorities, with a particular focus on segregation in nursing homes.

Dr. Charles Reynolds from the University of Pittsburgh School of Medicine described disparities in the U.S. health care system, explained why they exist, and shared ideas on what can be done to address these disparities.

Data shows that disparities in health care are real. Minorities have higher rates of disabilities and multiple chronic conditions. Minorities have lower rates of utilization of health services, including prevention. Compared to white patients, older black patients receive poorer management of chronic conditions, are less likely to receive procedures, are less likely to have satisfactory patient-physician relationships, and are more likely to use neighborhood health centers and ERs (versus private physicians). The relative rate of receiving “appropriate” care is a key issue. Delayed care received by blacks and Latinos may increase their likelihood of entering the

health care system with more severe medical conditions.

Understanding and addressing the disparities that exist is a public health imperative. This imperative will become even more pronounced as the number of older blacks will double by 2030 and the proportion of Latinos will triple. In addition, by 2030 there will be about 4 million LGBT persons aged 65 and older—persons also experiencing and at risk for inequalities in health care.

There are multiple reasons for these disparities. Among them: socioeconomic factors, physician attitudes, and cultural differences about seeking care and about the medical system—this includes more distrust among blacks and Latinos about clinicians, medical research, and physicians’ judgment. LGBT seniors also have trust issues as they are afraid that health care providers will not treat them with respect and dignity. Also, hospitals serving minority patients are more likely to have nursing shortages and to be inadequately funded.

Another significant factor is the lack of diversity in the health care workforce. Minority patients often prefer to be treated by health care professionals of the same ethnic background. But there is a shortage of minority clinicians. A 2004 report showed that African Americans, Hispanics, and American Indians represent less than 5% of dentists, 6% of physicians, and 9% of nurses. This underrepresentation is also reflected on the faculty of health sciences schools.

Suggestions for improvements include creating a more culturally competent health care workforce by:

- Increasing the number of minority health care providers.



Carol Raphael

“WE NEED VALUE-BASED PURCHASING THAT INCORPORATES EQUITY ISSUES AND DOES NOT DISADVANTAGE THOSE THAT ARE UNDER RESOURCED AND PROVIDES CARE TO MINORITIES.”

- Increasing the knowledge and skills needed in ethnogeriatrics. Doing so includes enhancing geriatric and ethnogeriatric competence in the general health care workforce while increasing the recruitment and retention of providers with special expertise in geriatrics and ethnogeriatrics.
- Ensuring appropriate access and quality for LGBT seniors. This starts with written policies on non-discrimination and can include training and workshops, outreach to LGBT communities, and partnering with LGBT care providers.

The actions that are needed must address both the micro issues (like patient/physician interaction) and the macro issues (like clinical resources and creation of a diverse workforce). Effective strategies for reducing disparities may include increasing minority access to primary care and dealing with overcrowding and longer wait times in ERs.

Dr. Vincent Mor focused on the quality consequences associated with nursing home segregation. Over the past four decades, the use of nursing homes by older blacks has increased while the use by whites has decreased. A “white flight” has taken place as whites have gone to assisted living facilities instead of nursing homes. Using the metaphor of public school segregation, assisted living facilities are analogous to “private schools.” The result is highly segregated nursing homes which mirror our segregated communities.

Those nursing homes which have a high percentage of black residents are more likely to be cited for harming residents, have the highest percentage of Medicaid

residents, are most likely to have been terminated from Medicare or Medicaid, and have lower than average nurse staffing. This pattern is identical for Hispanics. As such, in the nursing home context, disparities are primarily related to where a person is (such as in a poor neighborhood); not who he or she is since we find little evidence that minorities and whites are treated differently within facilities.

Carol Raphael, the President and CEO of the Visiting Nurse Services of New York, focused on the shift towards more home and community based services. She provided statistics indicating the increasing diversity of this population, and suggested that the corresponding home health care workforce should have similar diversity. An undervalued component of home care is cultural competency, a particularly important characteristic for those entering the homes of others. A related issue is continuity of care, because it takes time to develop relationships and a stable workforce is more likely to foster good relationships between caregivers and those receiving care. Adequate and consistent funding for Medicaid would help achieve these goals.

Policies to overcome segregation and disparities could include paying more for improvement and having communities take over failing nursing homes. But doing so requires having strong management and money to invest to turn facilities around. The idea of closing “bad” nursing homes may sound good, but what happens to the residents? In contemplating different strategies, bussing is an apt metaphor. The question is, will desegregating nursing homes be any more successful than with



Dr. Hyung Kim

“WE NEED TO EFFECT BOTH SUSTAINING AND PARADIGM-SHIFTING CHANGE.”

public schools, and is there a parallel to charter schools?

WHERE ARE WE GOING FROM HERE?

In this session, panelists offered their thoughts on the future of health care and long-term care. They shared visions of the future, discussed the obstacles to achieving these visions, and indicated policy changes to bring these visions about.

Dr. Robyn Stone, Executive Director of the Institute for the Future of Aging Services, offered a vision for long-term care (LTC). This vision is affected by multiple factors, including demographics. In the year 2000, the elderly population in the U.S. was 35 million; in 2050 it will exceed 85 million.

In thinking about a vision for LTC in 2030, there are certain givens. These include an aging population, an increasing gap between haves and have-nots, decreased availability of low-wage workers, transportation problems, and lack of affordable senior and disabled housing. Among the uncertainties that exist are the relative roles of the public and private sectors in financing LTC.

Dr. Stone offered a LTC “wish list” for 2030. It includes:

- **Financing.** She envisions financing for LTC in the U.S. that is similar to the German LTC insurance model. This would involve everyone paying in through premiums, and everyone would be covered who meets functional eligibility. States would perform eligibility requirements and there would be a safety net for the poor. Coverage would be modest, but private wrap-around policies would

be available. Financing related to disabilities would provide cash for services.

- **Delivery system.** There would be a range of home and community-based services. These would include residential options (such as affordable assisted living and housing with various services), with nursing homes for post-acute and end-of-life care. Technology will improve home-based care and there will be increased focus on primary/secondary prevention.
- **Devolution to communities.** Planning and implementation for LTC will take place at the community level. Standardized records will facilitate integration of acute, primary, and LTC services and increased consumer choice will be facilitated by availability of comparative quality information.
- **Workforce.** There will be an adequate workforce with the necessary skills to deliver LTC services. Creating this workforce requires that states provide incentives to create a new paradigm for LTC nursing and that there are federal and state incentives to develop geriatric and gerontological training for all LTC professionals. There needs to be an expansion of the caregiver pool, along with cross training that allows staff to work in multiple settings. Local communities must provide training for family caregivers.

Dr. Hyung Kim, Vice President of Research and Managing Partner of Transformational Development at Ascension, described a shared hope for brighter future. His vision focused on evolving from:

- Delivery of health care just in traditional facilities like clinics and hospi-

tals to include more environments people prefer, like homes and workplaces, both physically and virtually.

- Mainly doctors and nurses to team-based, revolving around navigators, caregivers, and direct care workers.
- A narrow disease orientation to more personalized and holistic segmentation.
- Local and regional regulations to unified regulations.

Bringing about this evolution requires policy changes, which are hard because there are entrenched interests. What is needed is to simultaneously effect both sustaining changes that improve the current system, and paradigm-shifting changes to transform the system. Transformative change requires a different kind of platform.

Principles for creating a transformational environment and platform are:

1. **Make it open.** Don't just involve experts, because success can come from unexpected sources. Engage creativity and insights from patients and their friends and family, and from clinicians and their staff.
2. **Protect it.** Protecting the status quo impedes progress, but so does "pulling up the carrot." We must look beyond existing regulations.
3. **Help it.** There needs to be an iterative planning process with advice and encouragement, connections and support, and tools and resources.
4. **Liberate money.** This goes beyond reimbursement. Start-up and expansion funding is needed to create transformation, and

customers should pay, since they will pay for what they value.

The challenge is to enact policies that will encourage improvement of the current system, while simultaneously creating and protecting an environment that provides structure, funding, and knowledge to nurture creativity and encourage transformative models.

CONCLUSIONS

This year's Princeton conference reiterated certain important facts and trends related to serving America's aging population. In particular:

- **Aging population.** As the baby boomers age and people live longer, the number of elderly Americans continues to increase. In 2000 there were 35 million Americans age 65 or over; in 2050 there will be more than 85 million.
- **Increased health care spending.** As the population ages and continues to spend more on health, health care spending continues to rise as a percentage of GDP. The day when Medicare's funding runs out draws ever closer.
- **Workforce shortage.** America lacks the necessary workforce to care for aging Americans. There is a shortage of geriatric specialists, a shortage of geriatric knowledge throughout health care, and a shortage of other types of health-related providers.
- **Significant disparities.** There are significant disparities in the care received by minorities. And, as bad as the workforce shortage is among the population in general, it is even more pronounced for minorities.

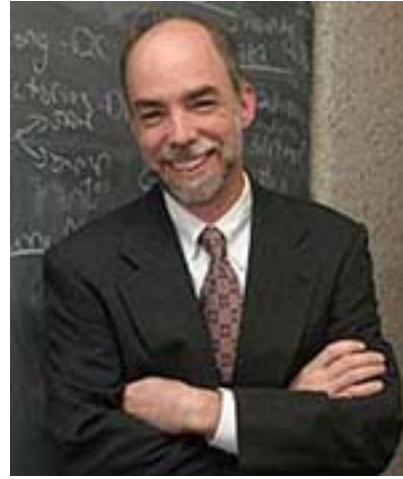
With these as some of the key challenges, conference speakers and participants identified several ideas and opportunities that deserve serious consideration. Among them:

- **Supplement physicians.** Train more nurse practitioners and direct-care workers (home health aides, nursing aides, etc.), and look at regulatory changes to allow more health care services to be provided by capable, lower-cost, non-physician health care providers. Also, provide more geriatric-focused training to all health care workers. Training more health care workers in areas such as geriatrics, palliative care, and ethnogeriatrics may require financial incentives from states and the federal government.
- **Reapply what works.** There are effective, diffusible models for caring for elderly patients with chronic diseases, and for delivering palliative care. These models include nurse-led care coordination, transitional care interventions, education programs, initiatives to drive behavior change, and more. Such models can improve the quality of care and reduce costs. These models must be reapplied.
- **Modify reimbursement.** Changes in payment policy need to be made to reimburse what has been proven to work (such as transitional care and palliative care) and to drive greater care coordination. Today, care for the elderly often takes place in silos, which results in suboptimal care and excess, unnecessary costs. Payment reform is a lever that can be used to drive greater care coordination. While bundled payment is not a panacea (it is complex, will have unintended consequences, and will be challenging to set the rates correctly and implement), some form of bundled payment seems necessary to drive more coordinated care.
- **Utilize technology.** Technology must play a key role in transforming health care. Technology such as electronic medical records and remote patient monitoring can make providers more efficient, can facilitate the coordination of care, and can result in delivering care in less costly settings, such as patients' homes.
- **Focusing on long-term care.** Long-term care is a critical aspect in caring for the aging population. There must be adequate and affordable LTC available to those who can't afford private assisted living. Government policies are needed related to LTC financing, with local policies for LTC delivery and staffing. Much can be learned by studying the LTC policies and programs of other countries such as Germany and Sweden.

Council on Health Care Economics and Policy



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