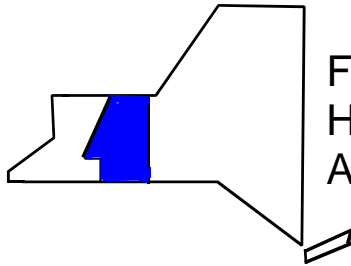


HOW WILL AN AGING POPULATION AFFECT HEALTH CARE?



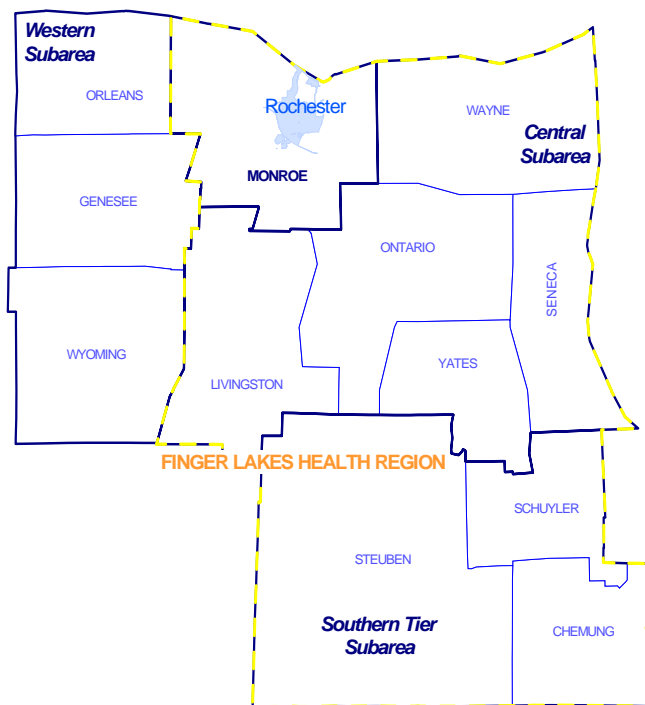
FINGER LAKES
HEALTH SYSTEMS
AGENCY

*Promoting the delivery of accessible, affordable health
care services to the population of the region.*

1150 University Avenue
Rochester, New York 14607
585-461-3520

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GENESEE REGION



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Rochester, NY 14607

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Introduction

If utilization rates do not change, the aging of the population in the 12-county Genesee region will generate the need for an additional 450 hospital beds, 3,200 nursing home beds, and 195,000 doctor visits by 2030. Of course health care practices are changing continuously, but these numbers illustrate the potential impact of the aging of the residents of the region on the health care sector.

The aging of the American population has become an influence on health care research as well as national and state economic, social, and health care policy. Today, health care consumes 14% of Gross Domestic Product. At the current rate of growth of health care costs and with the population aging, assuming no fundamental changes, 28% of the American economy will be spent on health care by 2030. More than one-third of national health care expenditures are currently attributable to people 65 or older. In the next 20 years, half of all health care encounters will involve older adults.

For consumers, local policymakers, and health care providers, sorting through all the forecasts and planning effectively for the delivery of services to a population that by 2030 will have 38 persons 65 or older for every 100 working age adults – compared to 23 per 100 today – is a challenge.

- Who is the focus of concern; is it defined by age (over 65 or over 85) or by disability or need for services?
- What diseases will we still need to consider? Of those diseases we worry about today, which will be cured, which will be chronic rather than terminal? What new diseases will face us?
- How will today's and yesterday's risk behaviors – sedentary lifestyle, substance abuse, etc. – affect health and health care needs in populations becoming elderly in the next thirty years?

Even with these uncertainties, we must plan for 278,000 people in this region who will be 65 or older, including 39,000 people who will be 85 or older, in 2030. The first baby boomers will not turn age 85 until 2030. From now until 2020, most of the growth in the older population will be among persons 65 to 74 years old, who are at lower risk of needing services than those 75 or older. This “lull” affords some time for planning.

The Finger Lakes Health Systems Agency has published this *Health Matters* to focus the discussion on some of the issues expected to affect, and be affected by, the aging population in the 12-county Genesee region: health care workforce, access, financing of health care. This *Health Matters* will be one in a series of papers about the impacts of an aging population on our region's health care. Future issues will be developed based upon the input of others involved in serving our older population, including health care providers, clinicians, insurers, public representatives, community-based organizations, and consumers.

The Demographics of Aging

The demographics of the senior population are changing. By 2030, if current trends continue, the senior population in the Genesee region will be:

- **More likely to live outside urban centers;**
- **More racially and ethnically diverse;**
- **Changing their living arrangements;**
- **Facing threats to their economic security.**

Growth in the Older Adult Population

The Baby Boom will become the Elder Boom.

The “population pyramid,” where each new generation is larger than the one before, is becoming the “population rectangle,” where population is distributed evenly across age groups.

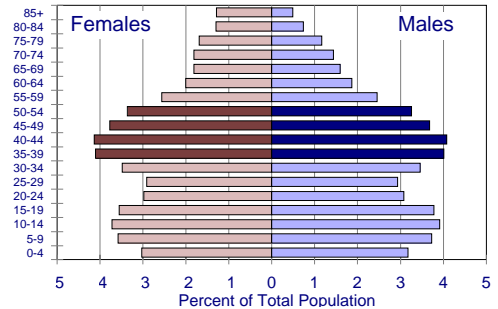
In 2011, the first of the baby boomers turns 65, and by 2015 the first large wave of boomers will be over the age of 65.

This growth is important not only in absolute numbers but also, as discussed later, in the ratio of older persons to working persons (the dependency ratio).

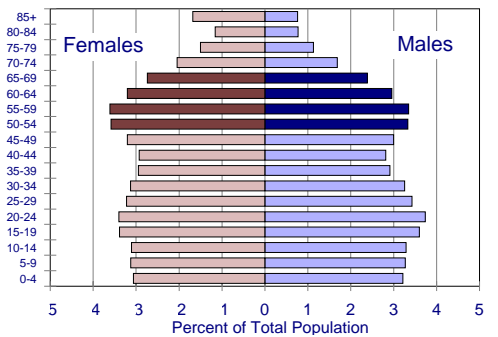
The senior population in the Genesee region is projected to grow by 48% from 2000 to 2030. **In 2030, 278,000 persons in the Genesee region, one in five, will be 65 or older.***

*Projections are taken from the Cornell Institute of Social & Economic Research

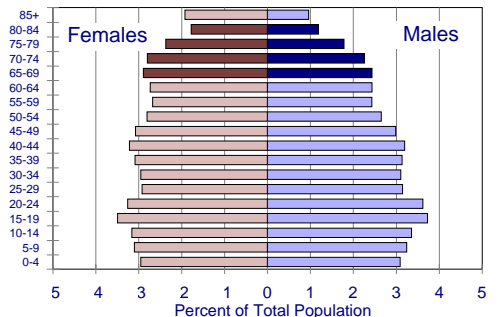
Genesee Region Population Distribution 2000



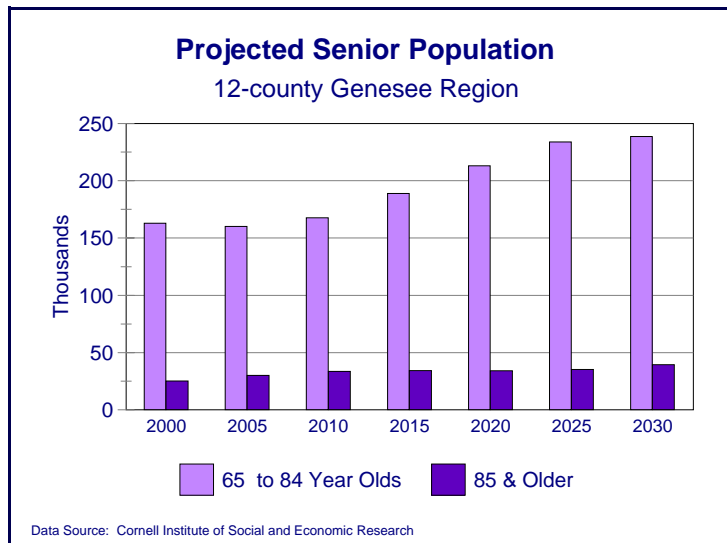
2015



2030



Over the next 30 years the population of adults 85 or older, who tend to have the heaviest need for long-term care, will grow faster than any other segment of the population. From 2000 to 2030 the population 85 or older in the Genesee region is projected to increase by 57% – from 25,000 to 39,000 people.

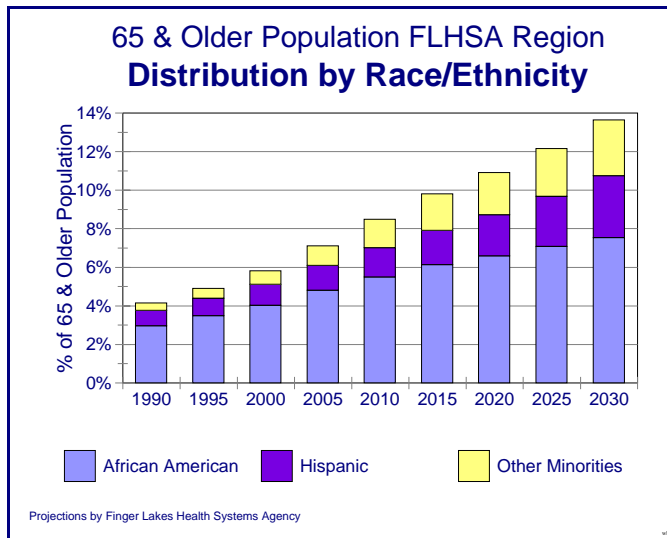


Faster Growth in Less Urban Areas

Between 2000 and 2030, the growth in the 65 or older population, and in the 85 or older population, will be greater in the region’s ten rural counties than in Chemung and Monroe Counties, the region’s urban counties. The ten rural counties will experience growth of more than 60% in the 65 or older population and almost 80% in the 85 or older population compared with growth rates of about 40% for each group in the two urban areas, Chemung and Monroe Counties.

Growing Racial and Ethnic Diversity

Between 2000 and 2030, we can expect to see a dramatic increase in the absolute number of older people of color, and people of color will make up a larger proportion of the older population. The percentage of seniors who are African American and Hispanic will increase from 5% to 11%.



Living Arrangements

In the Genesee region about one-third of older persons living in the community lived alone in 2000. Older women are more than twice as likely to live alone as men – 41% of women 65 or older living in the community lived alone compared to 19% of older men. The incidence of living alone increased with age. People living alone are more dependent on formal and informal supports for care.

It is difficult to know what living arrangements for seniors will look like in the future. In the last 20 years declines in mortality have been more rapid for men than for women, and this trend is projected to continue. Lower rates of widowhood have led to lower rates of women living alone. Confounding factors in considering projections of persons living alone, however, include increasing rates of older divorced individuals and, on the other hand, growing numbers of long-term non-traditional relationships.

Living arrangements for seniors vary by racial and ethnic group. In the Genesee region, older women in all racial groups are more likely to live alone than men; however, White women are more likely to live alone than African American or Hispanic women. National data show African American and Hispanic women are more likely than White women to live with “other relatives,” commonly children and grandchildren. African American and Hispanic families are also more likely to have three generations and extended family living together. As family income increases and as families become more mobile, extended family households become less common, a trend that may affect African American and Hispanic households of the future.

Threats to Economic Security

In the Genesee region, more than 12,500 older people (7%) lived below the poverty level in 1999.

Poverty rates across segments of the elderly vary markedly. While among the total senior population 7% lived in poverty, consider which segments of the senior population were in poverty in the Genesee region in 1999:

- Women – 9% of women compared with 5% of men;
- Older women – 10% of women 75 or older compared with 7% of those aged 65 to 74;
- People of color – 22% of African Americans and 25% of Latinos compared with 6% of Whites; and
- People living alone – 13% of those living alone compared with 7% of all persons 65 or older.

Hispanic women 75 or older living alone embody these disparities – 68% lived in poverty.

The poverty rates for Hispanic women 65 or older across the region were nearly 30% and in the city of Rochester approached 40%, in both areas more than three times that of White women. Poverty rates for African American women were somewhat lower – about 25%.

There are a number of threats to the future economic security of older adults. As people live longer, they are more likely to spend down their savings and assets to meet their medical care costs. Lifetime patterns of lower wages mean, on average, older people of color generally have accumulated fewer resources than Whites; the increasing diversity among the older population may mean a higher proportion of older people will be poor.

Pensions are “disappearing.” Defined benefit pension plans in which employers make contributions and promise a defined amount of income for the remainder of a former employee’s life are being replaced by defined contribution plans, in which benefit levels are dependent on voluntary supplemental contributions by employees and the growth of the stock market. If workers, particularly lower income workers and those who are far from retirement age, choose not to contribute, their retirement savings may not be sufficient.

Measures of net worth, at least half of which is generally derived from home equity and which is important in assuring availability of long term care, also indicate potential future issues. While present seniors have seen an increase in net worth, future seniors (those 45 to 54 now) have experienced a decline in net worth over the past 15 years. Further, there are sharp disparities between White and African American families in both size and trends in net worth.

Indicators of Potential Health Services Needs

The section which follows is necessarily brief, as we cannot predict what diseases will prevail thirty years from now. Many of the health conditions we focus on today are being more effectively managed, if not cured. There is widespread agreement that recent gains in life expectancy are tied to medical technology, and new drugs, devices, and medical procedures. In spite of advances in medicine, we continue to be challenged by diseases that are for the most part preventable by lifestyle changes such as nutrition, exercise, and reductions in smoking.

Health Status

Health status among seniors improves with each generation. Most older Americans report their health as “good” or better. In fact, in 2002, over 37% of seniors nationally reported their health was “very good” to “excellent.” From 1982 to 1999, the proportion of seniors 65 to 84 years old reporting very good to excellent health increased; however, among individuals 85 or older, the proportion actually declined.

Nationally 75% of older Whites report being at least in good health; 65% of Latinos and only 58% of African Americans report they are this healthy.

Low-income persons 50 or older are more likely than middle or high-income persons to say that their health is only fair or poor.

Mortality

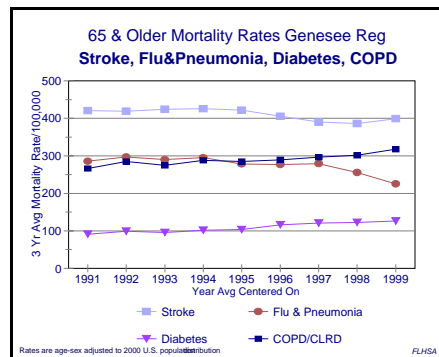
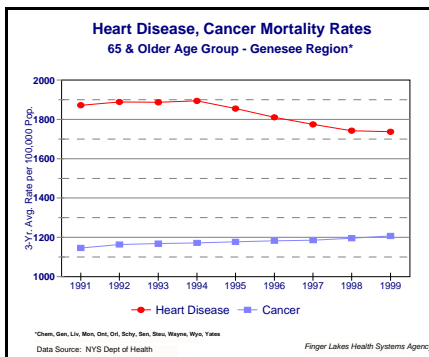
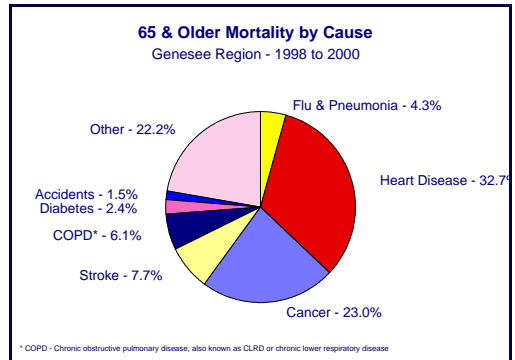
In the Genesee region, the overall mortality rate is declining, especially among younger persons. Among persons 75 or older, it has increased slightly over the last 10 years. In the future, if the decline in premature mortality is accompanied by postponement of morbidity, the length of time a person is ill before dying may decrease. Alternatively, if morbidity is not postponed, the time a person lives with a chronic illness before dying will increase. Such changes would have a significant effect on health care and on society at large.

While additional significant clinical advances will surely be made, further reductions in mortality will be dependent on personal choices to avoid behaviors that negatively affect health and cause premature mortality.

The leading causes of death among seniors in Upstate New York, accounting for more than half of the mortality, are cancer and heart disease, followed by stroke, chronic lower respiratory disease and pneumonia. It should be noted that the leading causes of mortality among Upstate African American elderly are slightly different, with diabetes replacing pneumonia as one of the top five causes. For those approaching their senior years (45 to 64 year olds) the five leading causes of mortality for

African Americans and Latinos include diabetes and AIDS which do not show up in the leading causes of death for the general population. Reductions in mortality rates for this population will require not only advances in clinical medicine and changes in behavior but also improvements in the cultural effectiveness of health care services.

- Over the last ten years, heart disease mortality in the Genesee region has decreased steadily among older adults – a 33% decrease among 45-64 year olds, 30% among 65-74 year olds, and 11% among those over age 75.
- Cancer mortality rates have decreased steadily among 45-64 year olds in the last ten years, falling by 15%. Rates have decreased 6% among 65-74 year olds but have risen by 18% among persons over 75 years old.
- For seniors of all ages, the chronic obstructive pulmonary disease (COPD) mortality rate has been increasing, with regional rates for seniors 75 and older generally higher than both upstate and national rates. However, declines in smoking rates – a primary cause of COPD – in the younger population may reduce the overall COPD rate in future years. (COPD is also known as CLRD or chronic lower respiratory disease.)
- Diabetes is an increasing problem in the U.S., rising both in prevalence and mortality. Mortality rates among adults 65 to 74 and 75 or older have increased substantially over the last 10 years (28% and 76% increase respectively). Increases in diabetes mortality rates among African Americans and Latinos have been even more dramatic.



Chronic Diseases

Chronic diseases are among the most prevalent, costly, and potentially preventable of all health problems. **Approximately 80% of persons 65 or older nationally have at least one chronic condition,¹ and 50% have at least two.** While clinical advances have reduced the effects of many chronic diseases – arthritis, hypertension, heart disease, cancer, diabetes, and stroke – our society has been unsuccessful in changing the behaviors that cause or exacerbate these diseases. With the exception of declines in smoking in some age groups, other behaviors including physical inactivity, poor nutrition and excessive alcohol consumption remain largely unchanged – if not worse. Behavioral risk factors contribute to 70% of the physical decline occurring with aging. Obesity, a preventable risk factor for chronic disease, is now an epidemic. Nationally, almost 75% of adults 55 to 64 years old are ‘overweight’ or ‘obese’.

In this area, the Monroe County Adult and Older Adult Report Card data indicate 80% of adults aged 18-64 and 93% of adults 65 or older have at least one risk factor for chronic disease (smoking, being overweight, physical inactivity, diabetes, high blood pressure, high blood cholesterol).

As adults in the U.S. live longer, the numbers of those living with Alzheimer’s disease will increase dramatically. Approximately 10% of people 65 or older and 47% of those 85 or older have the disease. However, advances in medications that hold significant promise to slow the progression of this disease make it difficult to speculate on the impact that people living with Alzheimers will have on the health care system.

¹ A chronic condition is defined by the National Center for Health Statistics as any specific illness, injury, or impairment ordinarily having a duration of longer than three months, though other surveys may use a 12-month duration with the requirement of needing medical care or of placing limitations on functioning., AARP, “Health Security,” p 111.

Disability

In the Genesee region, 38% of seniors living in the community reported having a disability² in 2000. Socioeconomic improvements (e.g., reduction in occupation-related risks, increased insurance coverage and access to health care, increased education) and medical advances have reduced disability rates in the last 20 years. However, the aging of the population means we can expect more older persons with functional limitations in the future. Relatively little is known about disability rates among “younger” persons (e.g., in their 40s with asthma, diabetes, obesity) and the effect that living with these conditions for thirty or forty years will have on their need for services and ability to live independently.

Behavioral Health

Mental Health

Almost 20% of older adults experience mental disorders that are not part of “normal aging.” Many older adults are never screened for or diagnosed with these illnesses. The Monroe County Adult and Older Adult Report data show adults 65 or older are significantly less likely than 18 to 64 year olds to say that a health professional or doctor had spoken with them about experiencing depression, anxiety, or stress in the last three years (19% and 30%, respectively). Only half of older adults acknowledging mental health problems actually receive treatment from a mental health provider.

Although the number of deaths from suicide is relatively small, the rate of suicide among older men is much higher than for any other age group; in the region, men 65 or older are 67% more likely to commit suicide than men 15 to 64 years old. Studies have found that many older adults who committed suicide had visited a primary care physician recently – 20% on the same day, 40% within one week; and 70% within one month of the suicide.

Persons 65 or older have been less likely than younger persons to receive/use mental health services. New York State’s 2001 biennial survey of state- and locally-operated programs showed individuals 65 or older in the Genesee region were less than half as likely as 35 to 64 year olds to have used those services. Among individuals using mental health services, individuals 65 or older used fewer services per person (1.08 in the survey week) than persons 18 to 64 years old (1.24).

²The Census asked two question regarding disability. One concerned the existence of a long-lasting condition such as blindness, deafness, or a severe vision or hearing impairment (sensory disability) or one substantially limiting one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying (physical disability). The second asked if an individual had a physical, mental, or emotional condition lasting 6 months or more making it difficult to learn, remember or concentrate (mental disability); dress, bathe or get around inside the house (self-care disability); or go outside the house alone to shop or visit a doctor’s office (going outside the house disability).

Alcohol and Other Drugs

Substance abuse in older persons is often not recognized, although alcohol and prescription drug misuse affect 17% of older adults (persons 60 or older).

Between 2% and 10% of older adults meet the criteria for alcohol abuse; the wide range of this estimate illustrates the difficulty of identifying the extent of the problem. Many of the typical ways of identifying alcohol abuse do not work with the elderly – e.g., many are no longer in the work force, where alcohol abuse problems among younger people are often identified. Older adults in Monroe County were significantly less likely than younger adults to say that a health professional or doctor had spoken to them about alcohol abuse in the past three years (9.5% and 16%, respectively). Because baby boomers moving toward old age have a higher rate of early alcohol problems than current seniors, drinking among older adults is likely to become an even greater problem in the relatively near future.

The abuse of illicit drugs is currently rare among older adults. There is concern, however, that the rate and number of older illicit drug users will increase as baby boomers with higher rates of lifetime illicit drug use age. Nationally, 0.3% of adults 65 or older reported using an illicit drug in the previous month, while 2% of 55 to 64 year olds and 5% of 35 to 54 year olds reported such use.

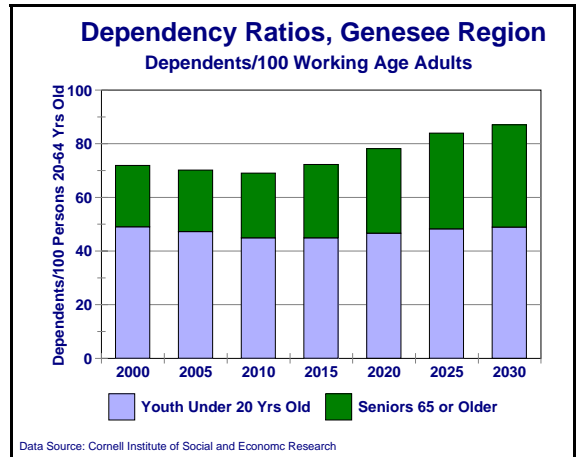
The misuse (or abuse) of “legal” drugs is of greater concern among the older population because people 65 or older consume more prescribed and over-the-counter medications than any other age group and experience more than half of all reported adverse drug reactions leading to hospitalization.

Who Will Care for Our Elders?

Most projections of the future assume elders will be able to live independently for longer periods of time. However, they will still require a variety of formal and informal caregiving – sometimes for short periods of rehabilitation following an adverse health event and, for many, more intensive care toward the end of life.

The challenge facing our society will be the fact that the working age population is shrinking, not only proportionately but also absolutely. In 1960, there were 5.1 workers per Social Security beneficiary, in 2000 there were 3.4, and that ratio is expected to fall to 2.1 by 2040.

In the Genesee region, the population 20-64 is projected to decrease by 11% between 2000 and 2030. During this same time period the older population is projected to increase by 48%. By 2030, in the Genesee region, there will be 87 “dependents” (older adults and children) for every 100 working-age adults, compared to 72 dependents in 2000.



This change will critically affect how health care is delivered and financed:

- The sandwich generation – ages 35 to 55 – currently described as an essential element of the safety net in our senior care system, will be shrinking. As the older population lives longer, the caregivers themselves become older: younger seniors caring for their frail elderly parents and increasingly-aged spouses and siblings caring for one another.
- As the workforce ages and career opportunities continue to expand for women, who make up the vast majority of workers in many health professions, the supply of health care workers is unlikely to keep pace with the growing demand for health care.
- The decline in the number of people in the workforce will tighten the employment market, making lower wage/ low skilled health care jobs (e.g., home care aide) less attractive.

- The number of employed persons contributing to the tax system, which finances much of health care through public programs, will be shrinking. This will lead to competing demands for tax dollars, with ultimately less money to support programs for seniors.

Compounding the aging of the health care workforce and growing demand for health care services are the existing shortages of certain health professionals and the expectation that without significant increases in the health care reimbursement system these shortages will persist. In addition, the shortage of geriatrics-prepared health care professionals is critical.

In the Central Finger Lakes region in 2000, the average age of nurses was 45, even older than nurses nationally, and insufficient numbers of baccalaureate-prepared nurses were available.

The current severe shortage of nursing assistants, home health and personal care aides, and other paraprofessional workers is central to the concern about the health care workforce. “Home health aide” is rated as one of the fastest growing jobs in both the Finger Lakes and Southern Tier regions between 1998 and 2008. Meanwhile, continuing care providers in New York State report annual turnover rates among nurses and aides of 30 to 40%.

Further complicating the workforce issue is the fact the racial/ethnic profile of the health care workforce is a mismatch with the region’s ethnic and racial mix. In a study of nurses in the Finger Lakes, 97% of respondents were non-Hispanic White, 2% were African American, and none were Hispanic compared with an older population that was 95% non-Hispanic White, 4% African American, and 1% Hispanic. Nationally there is a documented lack of diversity among physicians, nurses, dentists, and mental health professionals.

Finally, the changing racial/ ethnic composition of the older population may influence future patterns of caregiving. Historically the use of supportive services (i.e., formal vs. informal) has differed across racial and ethnic groups, with a higher use of informal supports and lower use of formal supports (nursing home and home health services) among persons of color. Whether that pattern continues as acculturation occurs and family structures change is unknown.

How Will We Pay for Care?

Reimbursement Issues

The majority of health care for the elderly is paid for with public dollars. As the number of elderly increases and the cost of health care rises annually, local, state, and national representatives have begun to develop policies to slow the rate of public spending for health care. The proposed policy changes range from restricting eligibility for services to shifting costs to individuals to shifting health care insurance for seniors to the private sector. However, there will be a growing reliance on public financial support for health care for seniors as fewer seniors retire with a defined health benefit and more of their retirement savings are used for out-of-pocket medical expenses.

All components of the health care system – primary care providers, hospitals, nursing homes and homecare agencies – state that current levels of Medicaid and Medicare reimbursement do not cover the cost of care for seniors and are calling for increased reimbursement in order to meet the needs of the senior population.

How these two opposing demands – a desire to control public spending and increasing demands for health care reimbursement – will be balanced is unclear. Historically, when health care costs have risen beyond the purchasers' (public or private) ability or willingness to pay, there has been a decline in support for prevention services and closure of facilities in outlying areas or facilities that predominantly serve the poor.

The Finger Lakes region has a long legacy of developing approaches to care that avoid these consequences including the development of new service and/or reimbursement models, avoidance of overuse of expensive services and sharing of the cost of care for those less able to afford care. Such innovations will be needed again.

Insurance Issues

The greatest health-related concern for seniors today is the amount of health care that is not paid for by insurance.

Medicare

Virtually all older Americans (97%) are covered by Medicare. While the program provides substantial relief from health care expenses, it does not cover many important services, including most long-term care, and increasingly requires substantial cost-sharing for many covered services. Medicare beneficiaries pay about 19% of their health care costs out of pocket. As noted below, these out-of-pocket expenditures are expected to continue to rise.

The recently signed *Medicare Prescription Drug, Improvement, and Modernization Act* is cited as the largest expansion of Medicare in its 38-year history. While a number of provisions provide subsidies and eliminate or reduce deductibles and co-payments for low-income individuals, other provisions will result in many low-income individuals actually paying more for drugs and may limit their access to some drugs. Provisions prohibiting the federal government from negotiating with drug companies for low prices have caused fears beneficiaries may actually pay more out of pocket.

Roughly 90% of Medicare beneficiaries supplement Medicare with coverage from other sources, including insurance from current or former employers, private individual “Medigap” insurance, Medicare+Choice plans, and Medicaid. These supplemental sources, however, have gaps in coverage and availability and, other than Medicaid, have high premium costs.

About 8% of Medicare beneficiaries 65 or older had no supplemental health insurance in 1997. **Beneficiaries without supplemental coverage are substantially more likely to have difficulty getting care** and to have no usual source of care. More than one in five (21%) beneficiaries without supplemental coverage reports delaying care because of cost.

In 2004, Medicare beneficiaries 65 to 69 years old in good health in the Genesee region are estimated to spend about \$4,500 to \$5,700, about 17 - 22% of their income, on health care. Assuming increases similar to those projected nationally and prior to the most recent changes in Medicare law, in 2025 these individuals could expect to have out-of-pocket costs of \$6,400 to \$8,000, about 21 - 27% of income. Individuals 85 or older in poor health are estimated to have out-of-pocket costs of \$5,400 to \$6,200 (26% to 30% of income) in 2004; by 2025 these individuals could expect out-of-pocket costs of \$7,700 to \$8,800 (32 to 36% of income).

None of these figures include expenses for nursing home care. Nursing home daily rates in the region average around \$250 – or \$91,000 annually. Except for limited periods immediately following a hospitalization, Medicare does not pay for nursing home care.

Medicaid

In New York State, 11% of Medicaid recipients are elderly, while 29% of Medicaid expenditures go for care of the aged. Medicaid is the primary payer of long-term care in New York State; nearly 80% of nursing home residents are Medicaid recipients, many of whom paid privately when they entered the nursing home but then exhausted their assets.

Private Health Coverage

The national forecast: expect very few employees to be eligible for retiree health benefits in the future. Between 1993 and 2003, the share of large employers offering health benefits to Medicare-eligible retirees dropped from 40% to 21%. In 2000 less than 8% of small employers offered

coverage to retirees of any age. And while there is evidence that Rochester-area employers provide retiree insurance coverage at greater than national rates, the trends and underlying forces apply locally as well.

“Offering” coverage does not mean paying for coverage. In 2002, 22% of employers with 500 or more workers “offering” early retiree benefits required retirees to pay more than 90%.

For workers contemplating early retirement, maintaining health insurance coverage is a significant factor. A 2001 GAO report noted a substantial portion (17%) of early retirees was uninsured. Retirees without employer coverage may find alternative coverage prohibitively expensive.

Working adults aged 55 and older are concerned about the potential effects of the Health Savings Accounts (HSAs) included in the Medicare drug bill and proposed Association Health Plans (AHPs). If the healthy switch into these plans, costs for individuals remaining in more traditional coverage may increase, which will further erode support for employer-sponsored coverage and ultimately shift more costs to older, sicker individuals or leave them without adequate coverage.

What are the Policy Implications?

There is a “lull before the storm.” The first baby boomers will not turn age 85, an age at which the need for long-term supportive service increases substantially, until 2030.

This “lull” affords time for planning, and, in fact, planning must begin now in order to effect the social policy and financing changes necessary to meet the challenges of serving the coming Elder Boom.

What do the baby boomers want their older years in 2030 and beyond to look like? Health care needs will certainly increase; what types of services can best meet these needs? How do we develop and arrange to pay for an accessible, responsive care and support system for 2030?

CAPACITY

- The older population, in particular the 85 or older population, is growing. Even with the advances in health care expected by 2030, many individuals 85 or older are likely to be in declining health, in need of assistance with daily activities, and in need of more health care services. Health and long-term care services delivery and financing will be challenged to respond to these demands.
- Do we need to plan for an extended period of poor health as the life span increases, or for a “compression of morbidity” where people stay healthy until a fairly short time before death? How will we provide for quality care and respect of individual wishes at the end of life?

ACCESS

- The population shift to rural counties in the region has significant implications for health care delivery, particularly if people do not move to more urban areas when they need additional services. Increasingly health care is regional with the most expensive and many of the “cutting edge” medical technologies and sub-specialists located at major medical centers in Rochester and Elmira. Access to those services for people in outlying areas – and coordination with primary care – will become critically important.
- In order to serve a diverse aging population, senior health care and long-term care providers will need to be culturally sensitive to their needs. Cultural beliefs and attitudes about aging and health care will need to be incorporated into provider training programs and care plans.

- Historically people of color have used fewer formal services than White people and have been more likely to live in three-generation and extended-family households. If these trends change with increased affluence and/ or mobility, the pressure on the service system to provide culturally appropriate care will be even greater.
- As an increasing number of older people choose to live in the community, the development of additional supportive services will be required to allow them to stay in their own homes.

FINANCING

- Seniors in the future will be squeezed by health care costs as traditional pensions disappear, retiree health benefits are cut, and out-of-pocket health care costs increase. The problem of financing health care services, particularly long-term care, needs to be addressed.
- Affordable access to care and medications for individuals without insurance to supplement Medicare will need to be developed.
- There are economic implications resulting from a decline in the working tax paying population. To the extent support services for the elderly are provided by county offices for aging, the tax base on which these services are funded will diminish. If philanthropic contributions decline, the services provided by independent community-based organizations will also be reduced.
- Adequate reimbursement for the care provided to seniors will need to be guaranteed in order to assure financial viability of health care providers.
- Counties cannot afford the current rate of increases in Medicaid expenditures. How will competing demands for tax dollars be resolved?

WORKFORCE

- With an increasing dependency ratio, we can expect caregiver burnout (and demand for nursing home admissions) to increase among informal caregivers unless additional supports are provided.
- A more diverse health care workforce needs to be developed to serve an increasingly diverse older population.

- Workforce issues, such as low wages, lack of benefits and perceived lack of respect and recognition, must be resolved in order to attract a workforce adequate to meet future service needs.

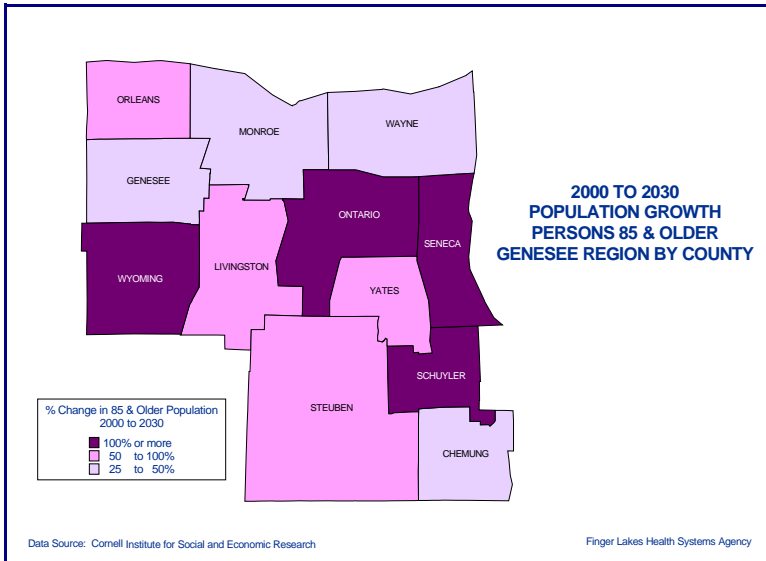
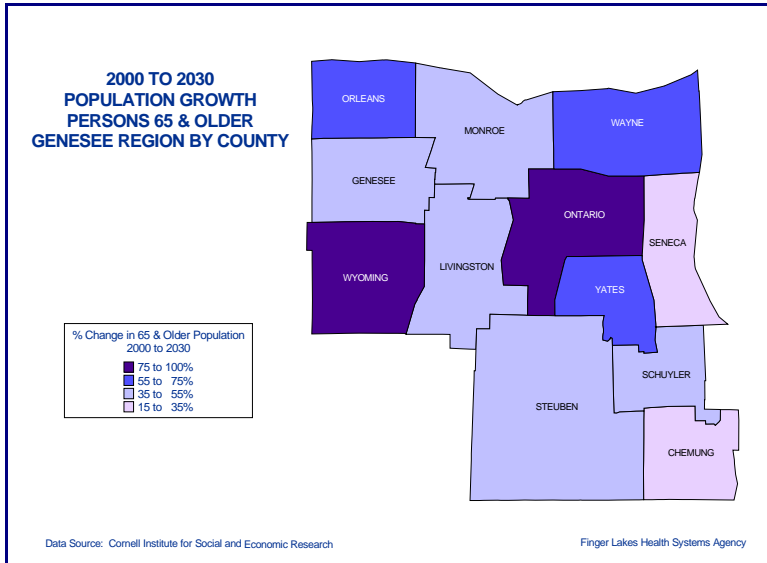
BEHAVIOR AND LIFESTYLE

- Poor health is not an inevitable consequence of aging. Behavioral risk factors, in particular poor nutrition and lack of physical exercise, need to be addressed in all age groups, but most especially among future seniors – today’s 45 to 64 year olds.
- Depression and substance abuse are not normal consequences of aging. Age-appropriate and effective mental health services must be considered a routine component of primary care. To ensure older adults receive needed services, identification of at-risk individuals through home health agencies, friends, staff of senior centers, health fairs, congregate meal sites, Meals on Wheels deliverers, etc. is essential.

Conclusions – “What Next?”

Our purpose in writing this paper is to highlight the areas we believe the community must consider as we look at changes in the health care system.

Each of these major topic areas needs to be further analyzed and, where we do not have local efforts to reverse negative trends, local interventions developed. Over the coming twelve months, the Finger Lakes Health Systems Agency will seek input from experts by convening mini-workgroups for each area to assess and recommend targeted community initiatives, actions, and options.



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Finger Lakes Health Systems Agency
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Finger Lakes Health Systems Agency (FLHSA) is a health planning organization whose mission is to promote the delivery of accessible, affordable health care services to the population of the region. From its origins in the 1950s, health planning has been an integral part of this community's health care system and has been supported by community leaders, health care providers, insurers, and county governments.

As health care in the region becomes increasingly competitive, FLHSA assesses the effects of that change on the community. It does this by:

- tracking shifts in access to health services and insurance
- monitoring changes in health status of the population
- assessing health needs in the community
- providing community-wide health data.