



## Management of Geriatric Care in the US

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### ABSTRACT

The federal administration on ageing anticipates that by 2030, 72 million (20% of total population) Americans will be above the age of 65 years. This number is almost 13% at present. Interestingly, every day nearly 10000 baby boomers enter the age group of 65 years. Also, almost 90% of the elderly have single or multiple chronic illness which needs continuous medical care. The problem is not the ageing population or increased prevalence to disease, but the acute shortage of trained clinicians to take care of the ageing population. According to the American Geriatrics Society, in the next fifteen years, America will have only one geriatrician for a population of 4000 elders. This prediction is strengthened by the fact that in 2014, there were almost 7500 practicing geriatricians in the US and in 2013, only 75 physicians opted for geriatric fellowship. Increasing life expectancy, increased burden of disease and decrease in the number of care providers is gradually leading to an inevitable situation, where the elders are left alone in the later years of their life. Few of these situations have been compiled on this article and probable solutions have also been discussed.

**Keywords--** Geriatrics, OECD, Older Adults

### I. GERIATRIC CARE IN THE USA

As compared to most of the countries, the United States has a very huge healthcare spending. Per capita, the United States spends more on healthcare than any other country in the Organization for Economic Co-operation and Development (OECD) – 22 percent more than second-ranked Luxembourg, 49 percent more than third-ranked Switzerland, and 2.4 times higher than the OECD average. While India, is spending 10% of OECD average. Elderly population in America also experiences problems, but in a different way. First and foremost is the difference in access to healthcare services. And the main reason being the lack of health insurance of any type. In the year 2000, more than 15% of Americans below 65 years were uninsured. A significant number of working Americans (sans insurance) have histories of serious ailments like diabetes, cardiac

problem, and depression. High cost of care was responsible for delay or non-availability of healthcare. Apart from this, social and demographic factors (including age, gender, race and education) have also been responsible for lack of access to care. It is also becoming evident that satisfaction with provider services may impact perceptions of access to health care and clinical outcomes.

From the available literature, it can be visualized that geriatrics or elderly care is an area, preferable neglected in most healthcare settings. Though, it is significantly mentioned in the healthcare policies, but implementation phase witness great deal of ignorance or neglect. According to an article published by the American Geriatric Society:

In response to the needs and demands of an aging population, geriatric medicine has grown rapidly during the past 3 decades. The discipline has defined its core values as well as the knowledge base and clinical skills needed to improve the health, functioning, and well-being of older persons and to provide appropriate palliative care. Geriatric medicine has developed new models of care, advanced the treatment of common geriatric conditions, and advocated for the health and health care of older persons. Nevertheless, at the beginning of the 21st century, the health care of older persons is at a crossroads. Despite the substantial progress that geriatric medicine has made, much more remains to be done to meet the healthcare needs of our aging population. The clinical, educational, and research approaches of the 20th century are unable to keep pace and require major revisions. Maintaining the status quo will mean falling further and further behind. The healthcare delivery and financing systems need fundamental redesign to improve quality and eliminate waste. As aptly mentioned in the public policy and aging report, this issue is not only related to financing problems, it also relates with the quantum of resources, which are consumed by the elderly population. The report reads: As the nation's older population grows, the U.S. will require a well-trained workforce of health care providers with expert knowledge in geriatric medicine. Compared with younger

adults, older Americans use a disproportionately larger share of health care services provided by physicians, nurses, pharmacists, physical therapists, and other practitioners. While people over age 65 represent 12 percent of the U.S. population, this group consumes one-third of healthcare services and occupies one-half of all physician time. Unfortunately, only a small share of the 650,000 medical doctors in practice today—including specialists whose patients are disproportionately elderly—receive the necessary training and education in geriatrics to provide older Americans with the best possible care. The American Geriatric Society in their report published in March 2013 have taken note of the demand and supply gap w.r.t. this issue. The report mentions that there are currently over 7,500 allopathic and osteopathic certified geriatricians in the US. It is projected that approximately 30% of the 65 plus patient population will need to be cared for by a geriatrician and that each geriatrician can care for a patient panel of 700 older adults. Based on these numbers, approximately 17,000 geriatricians are needed now to care for about 12 million older Americans. Due to the projected increase in the number of older Americans, it is estimated that approximately 30,000 geriatricians will be needed by 2030. To meet this need, this would require training approximately 1,200 geriatricians per year over the next 20 years. There are far fewer geriatric psychiatrists - currently there are less than 1,600. Furthermore, less than 1% of RNs, Pharmacists, and Physician Assistants; and about 2.6% of APRNs are certified in geriatrics. Additionally, approximately 3% of psychologists devote the majority of practice to older adults; and about 4% of social workers specialize in geriatrics. According to an article in the National Database of Indian medical journals, Vijay Roy and Rani Varsha have reported in their article that, In a report it was estimated that three out of four (75%) of elderly are taking medications. These account for 1/3 of all prescription medications in the United States. Estimated drug usage, including non-prescription medications, increases this estimate to 50% of all drugs used in the states. Too often, illness in older people are misdiagnosed, overlooked or dismissed as part of the normal aging process, simply because health professionals are not trained to recognize how diseases and drugs affect geriatrics.

Ann Bookman and Delia Kimbrel have taken the social aspect of this issue. In their article Families and Elder Care in the Twenty-First Century, they have pointed out how changes in both work and family life are complicating families' efforts to care for elderly relatives. Because almost 60 percent of elder caregivers today are employed, many forms of caregiving must now be "outsourced" to nonfamily members. And because elders are widely diverse by race and socioeconomic status, their families attach differing cultural meanings to care and have widely different resources with which to accomplish their care goals. Although the poorest elders have access to

some subsidized services, and the wealthiest can pay for services, many middle-class families cannot afford services that allow elders to age in their homes and avoid even more costly institutional care.

## II. US MODEL FOR GERIATRIC CARE FINANCING

Healthcare financing in the United States is regulated by the CMS (Center for Medicare and Medicaid Services). Most of the people in the age group of above 64 years are provided healthcare by a federally funded program, Medicare. It has four categories based on financing options: Medicare Part A, Part B, Part C and Part D. It is for those who have paid taxes during the working years of their life. Even after huge funding from Government, there are instances where money (out of pocket expenditure) must be paid in form of co-insurance and deductibles. Another program is Medicaid, which is for poor citizens and also funded at state and federal level. It is different for different states.

Healthcare is provided to older adults broadly at three levels:

1. Home healthcare
2. Hospital care
3. Care at centers

**Home Healthcare:** Is the provision of healthcare at home by formal and informal care-givers. People with chronic illness need home healthcare. Medicare will only cover this type if it is provided by skilled nursing staff or rehabilitation therapy.

**Hospital Care:** It includes care under the direct supervision of healthcare staff in a healthcare organization. It can be of various types based on the level of care required: Outpatient care, Inpatient care (includes skilled nursing facilities, acute hospital care, rehabilitation services).

**Care at centers:** Retirement homes or Assisted Living Centers provide care to independent elders with lower level of dependency. Skilled care may be provided upon request with additional cost. Decision to avail services from these centers rely primarily on the financial status of individual, as most of these are expensive options and normal insurance plans doesn't cover this type of care.

## III. PROBLEMS WITH THE AMERICAN HEALTHCARE SYSTEM

In its latest report on health in the US (2015), Organization for Economic Cooperation and Development raised concerns about the deteriorating healthcare system in the US. The significant reasons for a failure, cited in this report are: The inability of the US healthcare system to effectively treat chronic diseases, as diabetes, asthma. The differential life expectancy among

different races in America is another cause of concern, as black Americans have lower life expectancy and are more likely to be affected by chronic clinical conditions like diabetes and cancer. Another important issue raised in this report is the rapidly increasing obesity rates and substance abuse in the US.

Healthcare in America is the most expensive as compared to other developed economies. Increasing cost of hospital visit and medicines make it practically impossible for a large number of Americans to defer or cancel visit to healthcare facility.

According to a non-profit research and education organization, Physicians for a National Health Program (PNHP), American healthcare sector is struggling to reduce the cost of hospital care and there are serious flaws in the model, which is further dented by the outdated tax system which has not been revised for the last few decades. So, huge funding doesn't necessarily mean a better healthcare system or healthier population. All these factors are significant for eldercare, as in absence of a sound financial mechanism, the older adults are left vulnerable and prone to exploitation at various levels.

#### IV. THE WAY AHEAD

With the rapid increasing population in the elder age group, it is absolutely significant to have a robust mechanism to keep the healthcare care provisioning to this section, hassle free, effective and to-the-point. Based on the contemporary approach to achieve this target, following suggestions can be worth mentioning:

- Encouraging aging-in-place: This is not only cost effective, but also psychologically reassuring to the elders, who would primarily like to age in their own home and eventually spend the end years of their life at that place only. Relaxation of regulations pertaining to domiciliary care and nursing care for home care, can be a positive step. It can have dual advantage, as it can reduce load of geriatric patients in the healthcare facility and also it can bring down the cost of care for elders.
- Incentives to caregivers: Family caregivers spend a valuable time taking care of their dependent elders. This takes a toll on the professional and personal life of caregivers. Social security benefits or incentives can keep them motivated for the role of care-givers.
- Regulations for Assisted Living Centers: These centers need to be regulated even more strictly not only for the quality of care, but also for the cost of services. There has to be a uniform cost mechanism.
- Workforce augmentation: Trained workforce is the need of the hour to take care of an ageing America. The number of medical and para-medical staff trained in geriatrics needs to be proportionate with the ageing population. Incentives are required to encourage more medical professionals to pursue a career in geriatrics.

- Revision in Long-term Insurance: As ageing is inevitable, so, it's important to plan ahead for this. Awareness should be created for this during the working years of a person's life. Long term Insurance options should be made efficient and affordable for a vast majority of population.

#### V. CONCLUSION

Ageing of population is a simultaneous sign of success and despair. Success in terms of increased life expectancy and victory over life threatening diseases and conditions, and despair for the failure to provide a quality of life for elders in their later years. The problem has to be tackled with a multi-pronged approach, targeting shortage of workforce at one hand and encouraging family caregiving at another end. Financial dependence for elders also needs to be worked out to involve them in the mainstream. Moreover, healthier elder population will lead to less stress on the healthcare sector by reducing demand for preventive and curative care. The healthcare sector has to work in consonance with the political class and systems administration to towards a healthier life and healthier ageing for our senior citizens.

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