IFNF Presentation 1: Aging and Health Care for Older Adults in the U.S.

Slide 1:

My name is Joel Anderson, and I am an Associate Professor in the College of Nursing at the University of Tennessee. In this presentation, I will provide information about aging and health care for older adults in the U.S. This presentation is accompanied by a presentation about aging and health care for older adults in Japan from Drs. Hiroki Fukahori and Mariko Sakka.

Slide 2:

This project is funded by a grant from the Japan Foundation Center for Global Partnership to the International Family Nursing Foundation. I am a member of the International Family Nursing Association and co-chair of the Communications Committee. The content of the presentation is solely the responsibility of the author and does not necessarily represent the official views of the Japan Foundation Center for Global Partnership.

Slide 3:

The learning objectives for this first set of presentations are as follows: to describe trends in aging and the health of older adults in Japan and the U.S., and to compare the health care systems of Japan and the U.S. in terms of care of older adults.

Slide 4:

In this presentation, we will look at trends in aging and the health of older adults in the U.S., as well as the health care system of the U.S. in terms of care of older adults.

Slide 5:

First, let us take a look at trends in aging and health in the U.S.

Slide 6:

People worldwide are living longer. Today most people can expect to live into their sixties and beyond. Over the next three decades, the proportion of the world's population over the age of 60 will nearly double from 12% to 22%, from 1 billion to 2.1 billion in 2050. The number of persons aged 80 years or older is expected to triple by 2050 to reach 426 million. This pace of population aging is much faster than in the past.

Slide 7:

Every country in the world is experiencing growth in both the size and the proportion of older people in the population. All countries face major challenges to ensure their health and social systems are ready for this demographic shift. By 2050, two-thirds of the world's population over the age of 60 will live in low- and middle-income countries.

Slide 8:

This figure displays data from the World Health Organization visualizing the change in and distribution of the aging population globally over the next three decades. It's a stunning representation of how the percentage of the population over the age of 60 years is growing exponentially.

Slide 9:

In the U.S., we are seeing unprecedented demographic shifts with regard to age. By 2034, adults aged 65 and older will outnumber children under the age of 18 in the U.S. This gap will continue to grow over time with roughly 95 million older adults projected to be living in the U.S. by 2060 according to data from the U.S. Census Bureau. Driven by the aging "Baby Boom" generation, the U.S. population aged 80 and older will nearly triple by 2050, increasing to 31 million. The number of people aged 90 and older will quadruple to 8 million.

Slide 10:

This will dramatically shift the population as illustrated in this figure from the U.S. Census Bureau, taking our population from a pyramid to a pillar with impacts on health and health care needs as a result of this demographic shift.

Slide 11:

Both the U.S. birthrate, which is declining, and international migration play a role in these shifting demographics, as seen in this figure from the U.S. Census Bureau.

Slide 12:

In addition to changes in birthrates, we are seeing steep increases in life expectancy globally, particularly in high-income countries such as the U.S. and Japan. However, you can see there are differences by country, with the U.S. lagging behind and seeing a drop in overall life expectancy during the past several years.

Slide 13:

When we look at more U.S.-focused data, we see a more refined snapshot of disparities in life expectancy in the U.S. by sex and the intersectionality of race, as well as the impact of formal education on life expectancy. Black men and women and those without a college degree continue to have the lowest average life expectancy in the U.S. These differences in life expectancy are correlated with factors that constitute the health care system in the U.S.

Slide 14:

Now, let us shift our focus to health care for older adults in the U.S.

Slide 15:

One cannot talk about health care in the U.S. without a discussion of health insurance coverage. Given the lack of a single-payer or national health system, people in the U.S. must either pay out of pocket for health care services or rely on insurance coverage. The sources of health insurance coverage in the U.S. are illustrated on this slide. This figure is based on data from the U.S. Congressional Budget Office from 2019. People in the U.S. may have health insurance coverage from a variety of sources. These include insurance funded by the government, such as Medicare, Medicaid, and military insurance, or privately funded insurance, typically through one's employer.

Medicare provides insurance coverage for most older adults in the U.S. and was established in 1965 to provide health insurance to people aged 65 and older, regardless of income or medical history. Medicare helps to pay for hospital and physician visits, prescription medications, and other acute and post-acute care services. Medicare plays a major role in the U.S. health care system, accounting for 20% of total national health spending and 15% of the federal budget. Prior to the enactment of Medicare in 1965, less than half of all older adults in the U.S. had insurance to help pay for hospital and other medical services. Many were unable to obtain health insurance either because they could not afford it or because they were denied coverage based on their age and/or pre-existing health conditions.

Slide 16:

Medicare spending is expected to grow at a fast rate over the next several years because of growing enrollment related to the aging of the population, increased use of services and intensity of care, and rising health care prices. The U.S. Congressional Budget Office projects Medicare spending will double over the next 10 years to $1.3 trillion in 2029, increasing to 18% of the federal budget.

Slide 17:

Medicare covers a diverse population in terms of demographic characteristics and health status. A majority of beneficiaries are female, between the ages of 65 and 84, and report their health status as good or better. Women account for an even larger share of beneficiaries at older ages. More than three-quarters of beneficiaries are white, while 10% are black and 9% are Latino. As more people become eligible for Medicare and live into their 80s and beyond, the demographic characteristics of the Medicare population will change in terms of the age distribution and beneficiaries' physical and mental health, financial resources, and medical needs.

Slide 18:

In terms of health status, a majority of beneficiaries report being in good or better health, but one in four Medicare beneficiaries report being in fair or poor health. Close to half of beneficiaries live with four or more chronic conditions and 30% have a cognitive or mental impairment. One-third of beneficiaries have one or more limitations in activities of daily living, such as eating or bathing, that limit their ability to live independently. Most Medicare beneficiaries live at home; however, 5% live in a long-term care setting, such as a nursing home or assisted living facility. Women and beneficiaries age 85 and older and beneficiaries who are dually eligible for Medicare and Medicaid make up the majority of those living in long-term care.

Slide 19:

Medicare and Medicaid play important but different roles for people eligible for both programs. For the 10 million low-income older adults and people with disabilities covered under both programs, Medicare is their primary source of health insurance. Medicare covers most medical services, including inpatient and outpatient care, physician services, diagnostic and preventive care, and prescription medications. Medicare does not cover routine outpatient dental care or non-skilled long-term services and supports, such as in-home or extended home and personal

care in the community. Medicaid, a need-based program funded jointly by federal and state governments, pays for services not covered by Medicare. Older adults who qualify for both programs are poorer and have more medical needs than those covered by Medicare alone.

Slide 20:

Most Medicare beneficiaries have limited financial incomes and assets. A disproportionate share of those with low incomes and assets are women and racial and ethnic minorities. In 2013, half of all Medicare beneficiaries had incomes below $23,500 per person. This equates to roughly 200% of the federal poverty level. Income declines with age among older adults and is lower among women than men and among black and Latino older adults compared with their white peers. Income is higher among married beneficiaries and those with higher educational levels. Along with having relatively low incomes, many Medicare beneficiaries have relatively low levels of savings, with savings levels lower among women and racial and ethnic minorities.

Slide 21:

In addition to insurance coverage, one most consider access to care. For older adults, this can often mean access to acute care or hospitals. Data from the American Hospital Association regarding type of hospital are displayed in this figure. The majority of hospitals in the U.S. are community hospitals.

Slide 22:

Two-thirds of these community hospitals are located in urban areas of the U.S., with only a third located in rural communities. Populations in rural communities in the U.S. skew toward older demographics. Additionally, the majority of hospital closures in the U.S., which have been increasing in recent years, occur in rural areas, further limiting the availability of care providers for older adults. This also can have a profound impact on long-term care needs as we will see.

Slide 23:

Let us explore long-term care for older adults in the U.S.

Slide 24:

According to a poll conducted by the Associated Press and the University of Chicago in 2021, the top concern among adults in the U.S. is a loss of independence as one ages. This is followed closely by having the ability to pay for the care one needs and not being a burden on one's family. Social isolation and not planning enough for one's care needs round out the top five concerns. However, you can see from this figure adequate levels of concern related to having to leave one's home and having one's social needs met. Each of these are related to long-term care.

Slide 25:

As with health care coverage in the U.S., there are many types of long-term care for older adults in the U.S. Each comes with various levels of cost either to the older adult needing care, their families, or both. Politics and state policies set up variations in services depending on where you live. For example, in one state, there may be a fairly rational plan with a reasonable set of services available and reasonable accessibility to those who need these services. In another state, the availability of services may be more patchwork with many uncovered areas and types of services. This can occur even within the same state, particularly in terms of access between urban and rural areas. This patchwork has an impact on the long-term care services and supports available for those who rely on care from family or friends, remote care and adult day services, and home care.

Slide 26:

For those older adults residing in independent living communities, assisted living facilities, and skilled nursing facilities, policy at the federal and state levels has a more direct impact. A principal goal of long-term care policy in the U.S. has been to alleviate the high costs of residential long-term care (e.g., long-stay nursing home admissions) on state and federal Medicaid budgets, as well as costs to the older adult and their family. Included among current policy strategies to reduce residential long-term costs are rationing and targeting of services, shifting Medicaid and other public funding sources away from residential care towards community-based supports, and focusing on consumer-directed options.

Slide 27:

As mentioned previously, long-term care takes many forms in the U.S. There were an estimated 4.5 million long-term care workers in 2018. The majority of these individuals were working in facilities and half were aides or personal care workers. Given the increasing need for long-term care services and supports as the population of the U.S. ages and health care needs increase, one must consider the impact on the long-term care workforce and its viability. Currently, the majority of those providing long-term care in the U.S. are female and low wage. Nearly four in ten are aged 50 or older and a quarter are Black or African American. This is important when one considers that the impact and risk of chronic illness in the U.S. disproportionately falls on those with a similar demographic profile, as we saw with the life expectancy data earlier. Moreover, informal caregiving (i.e., caring for one's own family and/or friends) disproportionately is taken on by women in the U.S. This all has an impact on the workforce providing paid long-term care supports and services.

Slide 28:

Now let us take a look at family care of older adults in the U.S.

Slide 29:

Informal caregiving is at the core of long-term care in the U.S. Studies have attempted to estimate the economic value of informal caregiving of adults in the U.S. by considering the costs to replace informal caregivers with paid, in-home health care providers. Informal caregivers in the U.S. provide an estimated $470 billion in unpaid care annually. This far exceeds the amount of funding nursing homes or home health agencies currently receive. As with the formal long-term care workforce, the number of informal caregivers available to assist older adults in need is expected to decline over the next several decades, creating a family care gap.

Slide 30:

For those older adults living in the community, either independently or with family or friends, long-term care services are frequently supported by funding from the Older Americans Act. The Older Americans Act is considered a major vehicle for the organization and delivery of social and nutrition services to older adults and their caregivers. Congress passed the Older Americans Act in 1965 in response to a concern about a lack of community social services for older adults. The original legislation established authority for grants to states for community planning and social services, research and development projects, and personnel training. The law established the Administration on Aging to administer these newly created grant programs. The Older Americans Act authorizes a wide array of service programs through a national network of 56 state agencies on aging, 618 area agencies on aging, nearly 20,000 service providers, 281 Tribal organizations, and 1 Native Hawaiian organization representing 400 Tribes. The Older Americans Act also includes community service employment for low-income older adults; training, research, and demonstration activities in the field of aging; and elder rights protection.

Slide 31:

This figure illustrates how funding from the Older Americans Act is distributed. You can see that nearly three-quarters of funds are provided as grants to state and community and programs that support older adults. Of this funding, nearly half is spent on nutrition support services such as home-delivery of meals for those living at home or congregate meal settings for those living in senior housing or attending adult day services. Other ways these funds are used to support long-term care of older adults include transportation service, adult day services and senior centers, access to the health screenings, assistance in managing household affairs (such as financial and legal services), and other activities of daily living. How the funding is distributed depends on state and local programs and policy, as well as if and how funds are supplemented at the state and community levels.

Slide 32:

The Commission on Long-Term Care issued a report in 2013 that emphasized the need for a national family caregiving strategy rather than a patchwork of variable services and supports. This strategy came to fruition in 2017 when Congress passed the Recognize, Assist, Include, Support, and Engage Family Caregivers Act or RAISE. RAISE charged the federal Department of Health and Human Services to create a national family caregiver strategy focusing on the integration of family-centered approaches across care settings; advancing assessment and coordination in transitional care with families; providing information, education, and resources including respite care; and addressing the financial well-being of caregivers. Despite these recent national policy initiatives, the development and implementation of caregiver programs and policies remains largely in the hands of state and local policymakers where there is significant variability. Indeed, it is at the state level where most aging-related policies are administered that regulate long-term services and support. Given this variability, access and availability of these services is not well understood.

Slide 33:

A novel and promising example of a family-focused approach to long-term care of older adults comes from the state of Washington's Long-Term Services and Supports Trust Act of 2019. This program operates as a payroll tax whereby employers contribute to the Trust to result in a benefit up to $36,000 per state resident. Residents in the state of Washington can then use the benefit to purchase long-term services and supports, including adult day services, in-home help, home modification services, and family caregiver education. To date, Washington remains the only state in the U.S. to have formally implemented a comprehensive strategy to enhance the financing of and access to long-term services and supports, although various other models have been considered in several other states.

Slide 34:

Despite being recognized and documented for many years, disparities in health and health care have persisted and, in some cases, widened over time. This is particularly true for older adults. Black, Latino, and Indigenous older adults continue to fare worse compared with their White peers across most measures of health status, including physical and mental health status and prevalence of and death rates related to certain chronic conditions. Health disparities are symptoms of broader underlying social and economic inequities that reflect structural and systemic barriers and biases across sectors and have an impact on access to health care for older adults at all levels. Social determinants of health—the conditions in which people are born, grow, live, work, and age—are primary drivers of health. These include factors like socioeconomic status, level of education, neighborhood and the physical environment, employment status, and social support networks, as well as access to health care. For example, older adults living in rural communities often have more limited access to health care and service providers, as well as supports such as transportation options, compared with their peers living in urban areas.

Slide 35:

The rapid increase in the older adult population in the U.S. brings with it many issues that must be considered at the federal, state, and local level. Increased needs for health care and long-term services and supports require an examination of existing policies that support these programs, including the care workforce and the impact on families. All these issues must be viewed through a lens that takes into account social determinants of health and health equity.

Slide 36:

Thank you for your time and attention!

Slide 37:

Transcripts of this presentation in English and Japanese, as well as a complete list of references, can be found on the International Family Nursing Association website.

References:

Administration for Community Living. (2021b). *RAISE Family Caregiving Advisory Council*. https://acl.gov/programs/support-caregivers/raise-family-caregiving-advisory-council

American Hospital Association (2022). *Fast facts on U.S. hospitals*. https://www.aha.org/infographics/2020-07-24-fast-facts-infographics

Dawson, W. D., Bangerter, L. R., & Splaine, M. (2020). The politics of caregiving: Taking stock of state-level policies to support family caregivers. *Public Policy & Aging Report*, doi:10.1093/ppar/praa005

Gaugler, J. E. (2016). *Innovations in long-term care*. In L. K. George and K. F. Ferrraro (Eds.), Handbook of aging and the social sciences (pp. 419–439). Elsevier. doi:10.1016/B978-0-12-417235-7.00020-2

Gaugler, J. E. (2021). Bridging the family care gap. Academic Press.

Gaugler, J. E. (2022). Unpaid dementia caregiving: A policy and public health imperative. *Public Policy and Aging Report*. https://doi.org/10.1093/ppar/prac002

Kaiser Family Foundation (2020). *COVID-19 and workers at risk: Examining the long-term care workforce*. https://www.kff.org/report-section/covid-19-and-workers-at-risk-examining-the-long-term-care-workforce-issue-brief/

Kaiser Family Foundation (2019). *The facts on Medicare spending and financing*. https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/

Kaiser Family Foundation (2015). *A primer on Medicare: Key facts about the Medicare program and the people it covers*. https://www.kff.org/report-section/a-primer-on-medicare-what-does-medicare-cover/view/print/

Lipson, D. (2015). *The policy and political environment of family caregiving: A glass half full*. In J. E. Gaugler & R. L. Kane (Eds.), Family caregiving in the new normal (pp. 137–152). Academic Press.

Pope, N. D., Loeffler, D. N., & Ferrell, D. L. (2014). Aging in rural Appalachia: Perspectives from geriatric social service professionals. *Advances in Social Work*, 15(2), 522–537. doi: 10.18060/ 17059

Redfoot, D., Feinberg, L., & Houser, A. (2013). *The aging of the baby boom and the growing care gap: A look at future declines in the availability of family caregivers*. AARP Public Policy Institute.

Reinhard, S. C., Feinberg, L. F., Houser, A., Choula, R., & Evans, M. (2019). *Valuing the invaluable: 2019 update. AARP Public Policy Institute*. https://www.aarp.org/content/dam/aarp/ppi/2019/11/valuing-the-invaluable-2019-update-charting-apath-forward.doi.10.26419-2Fppi.00082.001.pdf

Spillman, B. C., Allen, E. H., & Favreault, M. (2020). *Informal caregiver supply and demographic changes: Review of the literature* (No. HHSP233201600024I). Assistant Secretary of Planning and Evaluation/Office of Behavioral Health, Disability, and Aging Policy.

https://aspe.hhs.gov/reports/informal-caregiversupply-demographic-changes-review-literature-0

World Health Organization. (2021). *Ageing and health*. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health