Demographics and Economics of Geriatric Patient Care in the USA

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Introduction

Health care for ageing Americans has been of concern since the middle of the 20th century when citizens over the age of 65 represented 8% of the population and only 1 in 8 had health insurance.[1] The federally-funded Medicare program was implemented in 1966 in response to this problem and, currently, the program insures more than 34 million elderly and disabled Americans. As of 2030, the Medicare program will have to grow to support 20% of the United States (US) population or approximately 77 million Americans.[2] Further, as of 2007, geriatric Americans over the age of 85 made up the fastest growing segment of the population.[3]

The ageing of the American population will bring significant fiscal pressures to bear on the Medicare program. Life expectancies are continuing to rise, and current retirees are projected to live approximately two years longer than retirees of previous generations, thereby spending more years in the Medicare program. Simultaneously, the labor force is expected to grow much more slowly than the population of retirees, resulting in a reduction in the number of workers per retiree. In 2000, there were 4.8 people ages 20 to 64 for each person age 65 or older. This ratio is expected to decrease by 2030 to approximately 2.9 people for each person age 65 or older.[*4] This imbalance in the funding mechanism is projected to result in insolvency of the Medicare Health Insurance program by 2019.[5]

Factors Beyond Population Ageing

Some health economists argue that technological innovation is a more significant factor influencing the rate of growth of health care expenditures for the elderly than the ageing of the population. In one recent French study, the rise in health care spending due to changes in medical practice was nearly four times higher than that due to population ageing. Further, morbidity reduction-induced savings more than offset the increase in spending due to ageing.[6] A separate cross-nation review found that countries with a focus on health care technology, as in the US, tend to spend relatively less on the oldest old than they do on the younger old.[7]

The addition of long term and home care services for the frail elderly will also strain resources. Organization for Economic Cooperation and Development (OECD) cross-nation projections

[*]Corresponding data for the Czech Republic indicate a parallel reduction in the ratio from 5:1 in 2000 to ~2.7:1 in 2030. (OECD Economic survey of the Czech Republic 2008. Available at: http://www.oecd.org/document/49 Accessed 3/26/2009.)

show that long term care costs will rise from an average of 1% of gross domestic product (GDP) in 2005 to between 2-4% of GDP by 2050.[8]

Finally, the majority of OECD member nations provide government assured health coverage, however, in the US a significant proportion of health expenses are paid for by the private sector.[9] A study of health benefit sustainability for the elderly in high income OECD nations showed that the proportion of health expenditures paid privately (rather than the proportion of elderly) strongly influenced total health expenditure. The study concluded that social policy decision-making predicted spending levels as much as demographics did.[10]

Implications for US Health Care Providers

The crisis in US health insurance funding for the elderly is of concern to policy makers and geriatric patients, but it is also of utmost concern to health care providers (hospitals and physicians) who rely on Medicare as a significant source of their revenues. In 2000, payments made by the Medicare program accounted for approximately 1/3 of total national spending on hospital services and approximately 1/5 of total national spending on physician and clinical services.[11]

Physicians in academic health centers (AHCs) are also dependent on the Medicare program for a significant flow of funds for the support of graduate medical education and care provided to indigent patients. All undergraduate medical students and almost 50% of all residents are trained in AHCs.[12] These are also the centers that provide most of the charity care and high-acuity medical specialty services (eg, neonatal, trauma intensive care, etc.) that are otherwise unsustainable without this supplemental federal funding.[13]

Conclusion

The US population, and that of developed nations around the world, is ageing. An ageing population, in combination with the spread of advancing technology and new geriatric patient services, is projected to strain economic resources well into the middle of the 21st century.

A plan to successfully confront the challenge of geriatric health care in the US must address opportunities to facilitate access, and the quality and value of health care for all Americans. The current US administration is proposing health care reform that will begin the dialog for change and will include plans to offer public options to private health insurance. However, the economic crisis and political considerations will pose significant resistance. Providers, and geriatric patients alike, share a significant stake in the outcome of plans to address these demographic and economic challenges in the provision of geriatric care in the future.

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