Preparing health care for baby boomers’ golden years

U.S. must address looming crisis of an aging population, IOM says

About 60 years ago, Kathleen Casey-Kirschling was born in Philadelphia. Since then, she’s been profiled on CNN and in national publications. When she filed for Social Security last year, the Commissioner of the Social Security Administration attended in person. Casey-Kirschling owes this attention to a simple quirk of timing: Born at a second past midnight on January 1, 1946, she is America’s first baby boomer.

Casey-Kirschling and her generation represent an impending explosion in the elderly population of the United States. In 2005, 37 million Americans were older than 65 years, making up about 12% of the country’s population. By 2030, analysts expect that number to grow to more than 70 million, nearly 20% of the country.

While this dramatic demographic shift has been anticipated for years, a recent report issued by the Institute of Medicine (IOM) points out that “little has been done to prepare the health care workforce” for this rapid growth. “Unless action is taken immediately, the health care workforce will lack the capacity (in both size and ability) to meet the needs of older patients in the future,” according to Retooling for an Aging America: Building the Health Care Workforce.

The document was produced by the 15-member Committee on the Future Health Care Workforce for Older Americans, chaired by John W. Rowe, MD, Professor, Department of Health Policy and Management, Columbia University Mailman School of Public Health. The committee includes representatives from several fields, including APhA member Miriam A. Mobley Smith, PharmD. They proposed a three-part approach: improve the competence of caregivers, supplement their recruitment and retention, and increase the flexibility of care. “Steps need to be taken immediately to increase overall workforce numbers and to use every worker efficiently,” the committee wrote.

Improving and increasing the workforce

The committee considered the “capacity of the health care workforce” the essential issue. In addition to finding the quality of existing education and training “inadequate in both scope and consistency,” the committee identified shortages in many geriatric care specialties and emphasized the “need for immediate and dramatic increases in the numbers of workers who care for older patients.” Fewer than 1% of pharmacists, physician assistants, and registered nurses are certified or specialize in geriatrics, according to the report.

Caring for older patients requires health professionals, direct-care workers such as nurse aides, informal caregivers, and others. The committee found that “the geriatric competence of virtually all members of the health care workforce needs to be improved” and recommended that hospitals encourage residents to receive training in geriatric care, certifying organizations require competence in the care of older patients, states and the federal government increase minimum training standards for direct-care workers, and public, private, and community organizations fund informal caregiver training.

The committee found that “opportunities for advanced training in geriatrics are scarce or nonexistent and ... very few take advantage of these programs.” To address this problem and promote recruitment and retention, they encouraged public and private payers to improve the reimbursement of geriatric specialists and urged states and the federal government to create loan-forgiveness programs, scholarships, and other financial incentives to aid specialists in geriatrics. Because “recruitment and retention are especially dire among direct-care workers,” the committee recommended that Medicaid programs increase pay for these caregivers.

Finally, the committee argued that the U.S. health care system has fundamental “deficiencies in quality” with respect to caring for older patients and presented a “vision for the future” incorporating three principles: comprehensive elder care, efficient provision of services, and active participation. However, the committee argued that “there is no single approach or best model that could be broadly adopted for all older patients” and encouraged flexibility. Specific recommendations include payers taking steps to promote proven effective and efficient models of care; Congress and health care foundations promoting relevant research programs; employers, regulators, and other groups expanding the roles of caregivers; and federal agencies supporting new technologies.

To reinforce these recommendations and monitor the industry’s progress, the committee also urged Congress to require annual reports from the Bureau of Health Professions to ensure that future problems are reduced or eliminated.

‘A sense of urgency’

While 2030 may seem distant, the committee argued that a “sense of urgency” is necessary. “The preparation of a competent health care workforce and widespread diffusion of effective models of care will require many years of effort,” they wrote. The year 2030 was chosen as a target to offer enough time to effect meaningful change without risking technological changes that would make the committee’s recommendations obsolete.

After an initial review of the document, APhA shares the concerns that the current health care model would be strained by an aging population. APhA is working on initiatives to change the pharmacy practice business model through programs such as medication therapy management (MTM), utilizing the pharmacist’s medication use expertise to improve patient outcomes, especially in the vulnerable elderly population. The Association also agrees that financial incentives in the health care system need to better support the level of care articulated in the report.

—Alex Egervary