

THE ENCYCLOPEDIA OF AGING

A Comprehensive Resource in Gerontology and Geriatrics

Fourth Edition

RICHARD SCHULZ, PhD
EDITOR-IN-CHIEF

Linda S. Noelker, PhD
Kenneth Rockwood, MD, FRCPC
Richard L. Sprott, PhD

ASSOCIATE EDITORS

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HEALTH CARE POLICY FOR OLDER ADULTS, HISTORY OF

Health care policy for older persons has developed incrementally throughout U.S. history following the evolution of the rule of government.

History

Health care policies can be divided into roughly 5 periods, characterized by different scopes and interests of the federal government in the health and welfare of the population.

Early Years of the Republic (1776–1860). Government involvement in the health of citizens initially was limited because such activities were seen as the responsibility of individuals and charities. Federal actions were limited to *quarantine* regulations at ports of entry, merchant seamen's health care, and smallpox vaccination. State and local governments were concerned with sanitation and the quarantine of communicable diseases during this time. Health care for the poor was left principally to private charities. Medical care was rudimentary. The few existing hospitals were intended to isolate people with communicable disease or provide care for the indigent. Different health care philosophies, including *allopathy*, *homeopathy*, *herbalism*, *public health*, and lay approaches all competed for legitimacy. The health of the population was poor by current standards: communicable diseases were common, infant and maternal mortality were high, and malnutrition was common among the poor. Life expectancy at birth in Massachusetts in 1798 was estimated to be only 35 years. As such, health care policy for older adults was nonexistent, as a result of limited life expectancy and the government's narrow focus.

Civil War to the Depression (1861–1931). The federal government assumed a limited role in promoting the health and welfare of the population. After 20 years of debate, Congress passed the *Food and Drug Act* in 1906 to regulate the adulteration and misbranding of food and drugs. While intended to protect consumers' pocketbooks, not their health, the act marked new federal involvement in a health-related area previously left to the states. Public health approaches were embraced at the state and local level. By 1915, public health agencies were established in every state and began to expand beyond infectious disease control to include water pollution, sewage disposal, nutrition, housing, and industrial accidents. The resulting improvements, along with improved social and economic conditions, are commonly credited with decreased morbidity and mortality during this period.

Allopathic medicine gained power as the *American Medical Association's* membership (founded 1847) and influence grew. Organized medicine and private foundations worked to base healing on science and to make medical education requirements uniform and high. Often unable to meet the new requirements, 92 *medical schools* closed their doors

or merged between 1902 and 1915, the number of homeopathic and eclectic schools fell by two-thirds, and 5 of the 7 black medical colleges closed. Hospitals became important sites where health care was provided, growing in number from 178 in 1873 to 4,000 by 1909. Payment for these health services remained the responsibility of individuals and charities. The government took interest in medical research and Congress voted to establish the *National Institutes of Health* (NIH) in 1930.

By 1900, *life expectancy* had risen to 47.3 years. Acute diseases accounted for the majority of deaths, led by influenza, pneumonia, and tuberculosis. The elderly comprised 4% of the population, and those who lived to age 65 had a remaining life expectancy of 11.9 years.

The New Deal to New Federalism (1933–1981). This era heralded important political-economic and scientific developments. The *Great Depression* and the *New Deal* brought dramatic new government involvement into the health and welfare of the population, while scientific discoveries furthered progress against infectious disease. This period was characterized by an active federal effort to enact policies to improve access, quality, and distribution of health care. The federal government also greatly expanded its involvement in medical research, beginning with the passage of the *National Cancer Act* in 1937. The National Institutes of Health grew from a small government laboratory to a biomedical research organization with worldwide significance.

Probably the most important piece of social legislation enacted in the history of the United States was the *Social Security Act* of 1935, establishing *social insurance* to assure a degree of financial security in old age. It also established unemployment insurance and federal aid to states for maternal and child health, public health, and public assistance. Other programs important to the elderly that would be established later, including Medicare, follow the principles established in this act.

After World War II, the federal government began to heavily subsidize hospital expansion, providing construction and modernization funds for hospitals, nursing homes, public health clinics, and rehabilitation centers in more than 3,000 communities over a 30-year period. The private, nonprofit institution became the primary type of medical institution because public hospitals, which largely served the poor, were last to receive federal construction

funds. New forms of health care financing emerged during this period. *Blue Cross and Blue Shield* medical insurance was established by hospitals and doctors during the Depression to help insure payment of their bills. Federal policies encouraged the spread of private health insurance by defining it as non-wage compensation, allowing workers to bargain for increased health benefits during wartime wage freezes and allowing both employers and employees to avoid taxes on premiums paid. The unemployed, poor, and elderly found private insurance difficult to obtain, leaving them dependent on charity and limited public programs. Blacks and other minorities also suffered from overt discrimination in the provision of care until passage of the Civil Rights Act and Medicare, in the mid-1960s.

Great Society programs in the 1960s continued New Deal trends. Federal medical insurance was established for the elderly and the poor through *Medicare* and *Medicaid*. To overcome organized medical opposition, Medicare incorporated the existing *fee-for-service* payment method and paid hospitals and doctors retrospectively according to what they charged. With guaranteed funding, hospital and nursing home construction and expansion continued, while new and costly technologies were introduced. By 1980, all public and private expenditures for health care equaled 9.4% of the gross national product, with 42% coming from public sources.

Infectious disease reduction slowed in the 1950s, as the major cause of death became chronic illnesses such as cancer and cardiovascular disease. The proportion of older persons in the population rose from 4.0% in 1900 to 11.3% in 1980, as life expectancy rose 50% to 73.7 years, infant mortality fell, and fertility patterns changed. Remaining life expectancy at age 65 increased to 16.4 years by 1980 (National Center for Health Statistics, 1995).

From 1965 to the mid-1970s the primary policy concern was expanding access to health care. As a result, doctor visits per person per year for the poor increased 30% and hospital use (discharges per 100 persons per year) increased between one- and two-thirds for the poor, elderly, and minorities. During this time the debate over national health insurance was seen as key to further health care improvements.

Health Policy under New Federalism and Fiscal Crisis (1981–1993). Federalism and devolution denote the relationships among different levels of government and the transfer of responsibility for

programs and services from the federal to the state level. Following President Richard Nixon's lead in initiating policies that increased state and local discretion and responsibilities in the 1970s, President Ronald Reagan vigorously pursued policies in the 1980s to diminish the federal role in health and welfare through block grants, program cuts, and increased state responsibility. A surge of "new" *federalism* initiatives emerged in the mid-1990s, releasing states from the burden of unfunded federal mandates and ushering in *welfare "reform"* that ended entitlement to cash assistance for the poor and imposed restrictions on public benefits for immigrants. A large body of research reveals that these latter policies reduced welfare rolls more than they did poverty itself. Inasmuch as work mandates led most recipients into low-wage service-sector jobs lacking health insurance benefits, we have greater numbers lacking basic preventive and acute-care. Older Americans have also been affected, because more grandparents now are needed to help raise the children of those subject to work mandates.

In its most extreme form, *new federalism* challenges the idea that there is any national responsibility for meeting basic human needs in health, income, housing, or welfare. Historically, it has been argued that because state and local governments do not have the revenue capacity of the federal government, national issues and problems necessitate a strong federal financing role. Moreover, aside from prohibitions against deficit spending, states and localities vary widely in their commitment to health and welfare benefits for the poor, disadvantaged, and the elderly (Estes, 1979; Estes & Gerard, 1983).

Deregulation is a hallmark of new federalism policy and *devolution*. Part of its impact in health care has been the increasing role of for-profit firms in government-financed programs. There is an increased *privatization of health care* with the growth of for-profits and the conversion of non-profits to for-profits in managed care. To promote "market competition" and further deregulation, some recent proposals suggest turning Medicare over to private insurers by permitting (or requiring) older persons to buy private insurance using government-supplied vouchers (called "premium support" proposals). Contentious issues are whether the financing of Medicare is privatized and what the effects of such dramatic policy change might be on older adults.

The current administration in Washington D.C. remains committed to attracting Medicare recipients into managed care plans, despite the high failure rate in recent years of those plans catering to older adults. This reflects the strongly ideological nature of health policy.

Two major forces have shaped health care policy for older persons during previous periods of health reform: (1) *austerity* and its political processing, and (2) the aging enterprise and the medical-industrial complex. *Austerity* has been a force of aging politics since the late 1970s as a result of state and local fiscal crises caused by taxpayer revolts, federal budget cuts, economic recession, tax cuts and high defense spending during the Reagan years and afterward. The result was a large federal budget deficit exceeding \$3 trillion by the conclusion of President George Bush's term in office in 1993.

Social constructions of reality become a force of their own (Estes, 1979). The concepts of *austerity* and *deficit reduction* have themselves become the driving ideology behind health and social policy for older adults since the mid-1990s. Austerity policies result from the socially constructed notions that: (1) federal spending on the elderly and poor is a major cause of U.S. economic problems, and (2) federal responsibility for health care is neither appropriate nor feasible. While the U.S. tax burden is lower than virtually all other large industrialized nations, austerity and deficit reduction are represented as the only possible response to declining revenues.

The aging enterprise and the medical-industrial complex consist of the growing concentration of private for-profit hospitals, nursing homes, and other medical care organizations, along with businesses related to medical goods and services (Estes, 1979; Relman, 1980; Wohl, 1984). With health care expenditures in the United States exceeding \$1 trillion per year (29% spent for the elderly), there are major incentives for corporate involvement in for-profit markets in medical care for older adults (Estes, Harrington, & Pellow, 2000). The growing role of proprietaries in medicine has intensified a perennial and profound question: should health care be a "market good" that is purchased as a commodity by those who can afford to pay, or should it be provided as a "merit good" available as a right or collective good, regardless of ability to pay (Estes, Gerard, Zones, & Swan, 1984)?

Clinton and Health and Long-Term Care Reform (1993–2000). As a candidate for president, Bill Clinton campaigned for *health care reform* that would include cost containment and universal health care coverage. His failed proposal would have provided a core benefit package through private and public plans managed by a *National Health Board*. Through this board the growth in health care costs would have been brought in line with inflation over a 5-year period. Coverage would have been paid for primarily by employers and partially by employees, depending on income level. When he addressed Congress in September 1993 there was general agreement, both in Congress and in the public, about the general principles of his plan.

A unique component of Clinton's plan was specifically addressing the issue of *long-term care*. In the final package brought to Congress in 1993 long-term care was presented as a "merit good" that should be available to all. The long-term care portion of the proposal was an advance over earlier proposals by offering coverage regardless of age or income. In the end, several key decisions reduced its political support; for example, a lack of fiscal relief to states that were given responsibility for long-term care under the plan. There was also no individual federal entitlement, and no defined benefit, with the exception of assessment, case management, and personal assistance services.

Today, more than a decade later, support for universal coverage is still high and as the population ages it is ever more concerned with funding and expanding options in long-term care. By 2004, the number of uninsured had grown to 45 million people (over 15% of the total U.S. population).

Scholars of health policy have analyzed the failure of the Clinton proposal. Central to this interpretation are the 3 incompatible goals of the Clinton plan: to provide universal health insurance, to reduce medical care cost increases, and to reduce the federal deficit (Lee, 2000). Those opposed to him, including new federalist Republicans in control of Congress as well as those opposed to universal coverage, particularly the health insurance industry, recognized this inconsistency and utilized it to mobilize against him (Lee, 2000). Although public support for universal health coverage was high, President Clinton's complicated proposal was manipulated and simplified in the media to create fear among the general public; the technocratic discourse surrounding it un-

dermined the potentially broad-based populist appeal the proposal might have enjoyed. Moreover, the charge of a large federal "takeover" of the health care system resurfaced in the 2004 election, when John Kerry advocated a federal contribution to pay for *catastrophic care*.

Even without passage of Clinton's 1993 health care reform, his administration can claim 2 significant improvements to health care coverage: the *Health Insurance Portability and Accountability Act (Kassabaum-Kennedy Act)* of 1996, and the *Child Health Insurance Program (CHIP)* as a part of the *Balanced Budget Act* of 1997. The former protects employees from losing health insurance when they change jobs, and the latter expands the number of poor children eligible for *Medicaid*, increasing the number of insured children by 2 million. (Greenberg, 2000)

Current and Projected Challenges: Prescription Drug Policy Under Medicare and Integrating Acute and Long-Term Care. In the 2000 presidential election health care was a leading topic. Candidates George Bush and Al Gore both advocated incremental changes to the health care system, such as the patient's bill of rights, *prescription drug coverage* for the elderly, and *tax credits* to help individuals buy their own health insurance. In the years since, the conciliatory approach of the Clinton plan—which sought to reconcile universal coverage with the interests of private insurers—has given way to a more polarized, ideological climate. More broadly, the backlash against managed care has exposed a lack of public trust in the health care system, low morale among clinicians, and frustration over the failure of *managed care* to translate into expanded access to care (Mechanic, 2001). Furthermore, the pincer effects on the federal budget, imposed by simultaneous tax cuts and military expenditures in Iraq and elsewhere, have intensified the sense of fiscal crisis that has long constrained health policy making. These factors have combined to produce cynicism about the efficacy of health policy reform.

Both in substantive and symbolic terms, the most significant recent event in health policy for the aged is the Bush-sponsored *Medicare Prescription Drug, Improvement, and Modernization Act* (P.L. 108-173), signed in December of 2003. Cost estimates of the plan have ranged from \$400 billion to more \$500 billion over 10 years. Although promoted as the centerpiece of Bush's "Compassionate

Conservative" domestic policy record during the 2004 election, this policy has been deeply controversial from the outset. According to a comprehensive analysis by Oliver and colleagues (2004), nearly 50% of senior citizens opposed the changes when they were signed into law, twice the percentage voicing support. Lobbying publicly in support of the plan, the AARP had thousands of members resign in protest and was accused of a conflict of interests rooted in the organization's long and close connections with private insurance companies. Beneficiaries face a confusing set of choices, including that of retaining private coverage, enrolling in a new free-standing drug plan, or entering a *Medicare managed care plan*. There are provisions for higher subsidy of low-income seniors, and a "gap" in coverage for many middle-class beneficiaries, who will be liable for out of pocket costs of \$3,600 or more.

There are several divisive elements of the plan, including the retreat from universalism (inherent in the tiered, means-tested targeting of benefits), and from the social insurance model of traditional Medicare; the plan's structure of incentives appear intended to draw enrollees out of traditional Medicare and into private health plans. According to Oliver and colleagues (2004), the legacies of earlier policy conflicts are inscribed in the current drug plan; these include its voluntary component, cost-sharing between taxpayers and beneficiaries, and substantial administrative control by private companies, rather than the federal government with its more powerful regulatory power. One must acknowledge the boldness of the Bush plan to address prescription drug coverage. In practical terms, the \$12,000 average prescription drug bill is among the "aging shocks" discussed by Knickman and Snell (2002); in political terms, the Bush drug plan allows the Republican Party to claim a major policy victory on an issue that has been a stalwart one for Democrats. The irony is that this step toward drug coverage contains incentives that appear certain to undermine traditional Medicare. When paired with the Bush proposal to partially *privatize Social Security*, one can reasonably detect that the underlying strategy is to dismantle the cornerstones of the federal government's old age welfare state. As Hudson argues (1999), the collective historical gains made by older adults in terms of health and economic security have prompted a counter-reaction; this is based on a more sanguine image of elders (especially against

the backdrop of retrenchment in spending on programs directed at children, such as the un-funded schooling mandates of "*No Child Left Behind*"), and also on alarmist warnings about the crushing burden that looms in coming years as the large baby boomer cohort becomes eligible for benefits. Thus, our final task is to scrutinize major myths (Geyman, 2003), claims, and findings bearing on the projected needs of this cohort on health care resources.

Future health care policy for the elderly will depend on at least 2 major conditions: (1) aggregate need, and (2) the political-economic environment. Aggregate need for health and long-term care by older adults in the 21st century will be determined by their numbers and health status, including chronic disease. Demographic projections show the number and proportion of elderly growing in the next century. By 2040, 21% of the population is expected to be aged 65 or older (vs. 11% in 1980) and to number between 70 million and 90 million (vs. 25 million in 1980). Disability rates during the 1990s have been calculated at 38% for men and 42% for women (Kaye, La Plante, Carlson, & Wenger, 1996). Despite evidence of some declines in the disability rates, increases in the number of older adults will exacerbate the call for an adequate long-term care policy. In the future there will be an "increasing number of individuals in quite good health nearly up to the point of death and an increasing number with prolonged severe limitation, with a decline in the duration of infirmity" (Rice & Feldman, 1985). Chronic care services are particularly important for older women and minorities, who are least able to pay out of pocket. Minority elderly, historically small in number, are increasing faster than white elderly and will need expanded, culturally relevant, affordable low-cost health and long-term care.

Knickman and Snell (2002) directly address the alarm surrounding the aging baby boomers, who "in the year 2030 will be aged 66 to 84—the '*young old*'—and will number 61 million people." Their analyses show that total dependency ratios in 2030 will not be appreciably higher than they were during the 1960s, when the youth dependency rate increased with the entry of the baby boomers. Moreover, the authors urge care in the definition of "dependent," inasmuch as this cohort will be better educated, have lower rates of many chronic disabilities, and will thus be even more vital as volunteer and community resources than are current older

adults. Clearly, this potential capacity—central to a broader healthy aging/wellness model—will be realized only to the extent that we are successful in channeling the talents of older adults into significant roles and institutions. This integration will require extensive public-private partnerships of a sort that is difficult to envision in the current political environment. Furthermore, given the continued growth in the numbers of the oldest-old, even the most optimistic projections regarding disability will require major changes in the funding and balancing of our long-term care system (to expand and better integrate community care options). Although too rarely discussed in the context of health policy, a fundamental challenge we face is in recruiting and rewarding the tens of thousands of frontline care workers who are central to the quality of life for older adults in assisted living as well as nursing homes (Wellin & Jaffe, 2004).

Finally, we do have models for better integrating acute and long-term care, which are certain to be in greater demand as baby boomers age. (Indeed, providing for the “least restrictive” care setting is now legally mandated, after the Supreme Court’s 1999 *Olmstead Act* ruled that doing otherwise is in violation of the Americans with Disabilities Act.) For example, in 1997 the *Program of All-Inclusive Care for the Elderly* (PACE model) was designated as a permanent program in Medicare; Gross and colleagues explain (2004): “The program’s objective is to enable individuals to continue living in the community as long as possible. It achieves this objective by offering a comprehensive set of medical, psychosocial, and long-term care services. At the core of the program is adult day care, augmented by home care and meals at home.” There are now some 10,000 elders enrolled in PACE, a considerable number, although a fraction of the estimated 3 million community-dwelling, nursing home-certifiable persons who could potentially benefit (Gross, Temkin-Greener, Kunitz, & Mukamel, 2004). These authors conclude that lack of public knowledge of such programs, competition (from for-profit as well as other state-operated programs), staffing shortages, system fragmentation between acute-care and community providers, and difficulties in penetrating the market of non-Medicaid eligible clients are all implicated in the disappointing rate of growth in PACE programs. Also, they point out that the growth of the nursing home industry, to

which PACE seeks to offer an alternative, was fueled by massive federal support that PACE programs have not enjoyed. Finding strategies for expanding and sustaining such integrated care options will be a key to promoting the flexible, integrated care programs we know to be both desired and effective.

If health policy continues to be driven by the devolution of federal responsibility, deregulation, austerity, and an increasingly powerful medical-industrial complex, then privatization, corporatization, fragmentation, and rationing of health care will worsen. Continued federal budget cuts and shifting of responsibility for medical care for the uninsured to states, localities, and individuals could return the nation back to an earlier era of health policy when the federal government took little active interest in the health and welfare of the populace and policies were made at the state and local level. Such an approach leaves the basic health care financing system intact but augments the power and influence of a highly pluralistic and profitable medical industrial complex, while doing little or nothing about the growing urgency to address the need for long-term care.

Among current calls for partial *privatization* of Social Security, Medicare, medical savings accounts and private long-term care insurance, none acknowledge the greater medical needs and out-of-pocket expenses of the poor, the disabled, chronically ill, minorities, and women. A major question concerns who will pay for the costs of these “unprofitable” patients. Relegating health care distribution to the market and to managed care requires that consumers are sufficiently informed so they are able to make the best choice and so that access automatically flows from market decisions. However, from where public knowledge of costs, quality, and optimal treatments will come remains problematic. More importantly, competition is not likely to produce access without universal coverage (Teisberg, Porter & Brown, 1994). As such, the health policy debate and reforms for older persons in the future are indivisible from struggles to achieve universal coverage of health and long-term care in the face of a powerful and well-entrenched, pluralistically financed medical care system (government, private insurance, and out-of-pocket) and a largely private, profit-driven delivery system. The challenge, as stated, is to finance, link, and integrate acute care and community-based long-term care services.

If coalitions were to be formed that transcend age and unite groups with common interests (e.g., the elderly and the disabled), they could change the fundamental conditions that presently affect health policy. In the place of austerity and new federalism, they will have to define the right to health care as part of the Constitution's federal mandate to "promote the general welfare." These groups could become successful advocates for the organization, financing, and delivery of health care for the elderly and disabled as a continuum ranging from respite care to the relief of families who provide most of the care, adequate incomes, and acute medical services. The looming battle over Social Security, affecting millions of beneficiaries who are disabled workers and children as well as older adults, may catalyze such a coalition.

CARROLL L. ESTES
CHRIS WELLIN
DAWN D. OGAWA
TRACY WEITZ

See also

Health Care: Financing, Use, and Organization

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HEALTH INFORMATICS

Definition

Health informatics uses information technology and techniques to support clinical care, health services administration, health services research, and public and provider education (Shortliffe & Fagan, 2000; Bommel & Musen, 1997; Wyatt & Liu, 2002; Wyatt & Keen, 2001). The integration of ideas from