Trends in the Health Sciences

Looking through a glass darkly: Challenges ahead in health care for older adults

The 21st century offers people the most advanced, effective, and safe medical interventions for preventing and treating disease. Life expectancy has climbed by 30 years or more in just a few decades, allowing people newfound flexibility in their lives — perhaps starting families later in life, enjoying more years of retirement, or if they wish, working well past the “old” retirement age of 65. What could be wrong with this picture?

“Looking at a future with dramatic increases in the number of older adults, the biggest challenge our health care system faces are shortages in medicine, nursing, pharmacy, really all of the disciplines,” said Tomas L. Griebling, MD, MPH, chair of GSA’s Health Sciences Section for 2016–17. “There are already huge shortages, and predictions are for those to worsen given the sheer volume of care we’ll need to provide.”

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1. A numbers game: Too many older adults, not enough providers

“I’m a urologic surgeon, and I can tell you we’re already drastically behind in the number of urologists that we need in the United States,” Griebling said in addressing what to do with more than 70 million baby boomers who are reaching retirement age — 10,000 of them every day. “The problem is that there are a lot of challenges in trying to increase that pool in that short period of time.”

Those challenges include inadequate funding of graduate medical education and a maldistribution of practitioners. Older adults make up a large proportion of patients seen by certain medical specialists—ophthalmology, cardiology, and urology in particular. “The number of residents and fellows in those training programs will increase only with increased funding, something that doesn’t seem likely given the discussions going on now about health care costs,” Griebling said. And if the number of specialists coming out those training programs is reduced because of federal budget cuts, the supply of practitioners will be even more inadequate as baby boomer physicians leave the workforce.

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2. Changes in health care financing: Implications for the older adult

Only a few weeks into the Trump administration, change is a certainty, but the impact of those changes in federal support of health care is difficult to assess. For older adults, even well-worn and comfortable coverage of Medicare could be in play, if efforts to privatize the system succeed.

“My personal view is the Affordable Care Act had several benefits, but it also produced some significant risks,” Griebling said. “Hopefully we will end up keeping the good parts and modifying those aspects that weren’t really working that well. I know some older adults who have been in situations where they’ve been notified by their third party insurance that they have to change their secondary Medicare plans or modify plans through their retirement or their spouse’s retirement. Those kind of changes were already looming before the change of administrations, and I think the degree to which they’ll change, the way in which they’ll change, is really unknown right now.”

One thing is for sure — changes in the system are likely to be designed to address the increasing number of older adults who are living longer and fewer workers whose taxes are flowing into the funds providing them with benefits.

“The benefit of life-extending treatments or therapies like those talked about in the Biological Sciences Trends article is that you could improve functional status, allow people to live longer and healthier lives rather than necessarily having a degree of frailty or decline that you see currently,” Griebling added. “Those kind of targeted treatments, therapies, and prevention strategies are exciting, but the question is of the cost.”

3. Changes in healthcare financing: Implications for the provider

Patients are not the only ones worried about Congressional tinkering with the financial engine that drives the American health care system. Many physicians already decline to participate in the Medicare system, citing low payments, and health systems are very concerned about proposed changes in Medicaid that could return many of their patients to uninsured status without a compensatory increase in reimbursement for indigent care.

Already, access to care is affected by low Medicare reimbursement rates. “Older adults who want to or need to see one of these nonparticipating providers are in the lurch,” Griebling said. “They have to figure out a way to pay if they don’t have secondary coverage, what their out-of-pocket expenses are, and things like that. The problem is that it’s not feasible for a lot of providers to participate in the program. I think this raises some ethical questions about practice, access to care, and choices providers are making. Reimbursement is certainly a key issue that will affect care of older adults in coming years.”

“The other reimbursement issue that we’ve seen for many years is that geriatrics—even though it is a boarded subspecialty within family medicine or internal medicine — has generally been reimbursed at a much lower rate than other subspecialties that require similar numbers of years of training,” Griebling continued. These low rates have historically suppressed the number of physicians choosing geriatrics as a career.

4. Trends in therapeutics: Targeted therapies, precision care, technology

Despite these gloom-and-doom assessments of financing and reimbursement trends, the fact is that most older adults currently have health care coverage and are being treated with some of the safest, most effective medications and therapies ever and with advanced, innovative technology. That trend will continue as medical research continues to uncover disease mechanisms and develop innovative ways to counter those effects in conditions such as cancers, neurocognitive disease, and urologic conditions such as incontinence and infections caused by resistant bacteria.

“Medications today have better safety and efficacy profiles and fewer side effects for older adults than in the past,” Griebling said. “I think one of the biggest challenges is that almost all clinical trials for medication approval are done in relatively healthy, often younger populations, and they’re designed that way to control for a variety of variables. The problem after approval is that those medications are used in a very different context. They’re often used in patients with significant comorbidity, other functional issues.

“The side effect profile and the issue of drug interactions with polypharmacy can be significant, and we don’t necessarily know what those changes or issues will be. From my perspective and those of other experts, there need to be more focused and targeted clinical trials that
include older adults with underlying comorbidity or more vulnerable populations to help answer some of these questions.

Technology is driving innovation in health care, particularly in imaging, other diagnostic modalities, and cardiac monitoring, Griebling noted. For older patients, the advent of "minimally invasive surgical techniques has really altered the face of geriatric surgery and geriatric surgical care," he added. "In the past, surgery was more invasive, and its risks often outweighed the benefit for older adult patients. The combination of procedures and technology that have made things less invasive with better outcomes combined with a better understanding of how to optimize patients' health and their comorbidities prior to surgery have really led to a change in the way that we approach patients who may need surgical therapy." With proper preoperative and perioperative evaluation and care as outlined in 2012 by the American College of Surgeons and the American Geriatrics Society, surgery becomes a reasonable option for many older adults who in the past would not have been able to withstand previously used surgical techniques.

5. Geriatric syndromes: What’s really important

Given the workforce shortage and reimbursement difficulties, geriatric practitioners are hard pressed to provide more care to older adults. But they are finding ways of providing smarter care by focusing on geriatric syndromes rather than discrete diagnoses. It’s really a way of treating the whole person instead of care that is restricted by organ system or physician specialty. Syndrome-based care is also useful in pulling an interprofessional team together as physicians, nurses, pharmacists, and allied health professionals apply their unique skills and knowledge to problems in older adults such as incontinence, falls, delirium, pressure ulcers, wound care, and polypharmacy. Given the wrong circumstances, inadequate treatment of any of these syndromes can put an older adult on the slippery slope that leads to decline, frailty, and often death.

Using urology as an example, Griebling said, “Among geriatricians, urinary incontinence is typically seen as a syndrome. However, as urologists, we tend to view it more as a diagnosis and then a sort of subdiagnoses within that — stress incontinence, urge incontinence, or overflow incontinence. But viewing incontinence as a syndrome may be more effective, as it is a multifactorial condition and can be brought on or worsened through factors as diverse as medications, fluid intake, diet, and behavioral patterns. It can be a challenge for urologists to understand that this is more of a syndrome than a straightforward diagnosis. Having geriatricians help their colleagues get to this realization can be very important in caring for patients and in preventing decline.”

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6. Improving transitions of care through value-based care

“In the past, physicians and nurses often felt, ‘We do the acute care and then the patient just sort of...what happens?’” Griebling said. Health care financing in the United States is shifting toward value-based care, and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is law and has been translated into regulation. Given the resulting clinical and economic importance of reducing rehospitalizations and improving patient satisfaction with care, everyone is paying more attention to the transition from acute care to rehabilitation facilities, the community, or long-term care.
Within this equation, a very important and often overlooked factor is the caregiver, Griebling said. “This requires more than understanding caregiver burden,” he emphasized. “We have to look at the very real issues in the ‘sandwich generation’—a population that is now caring for older adult family members as well as young children.”

7. End-of-life care
Advances in hospice and palliative care will continue in the future, Griebling believes, and the care needed by those at the end of life is better understood. Just as important, though, is getting people to talk about this phase of life earlier and to be more accepting of the type of care that will inevitably be needed.

“Research and evidence show strong benefits of that type of care for people who need it and their families and loved ones, but the fact is that it often isn’t selected — or even provided as an option — until the very end,” Griebling said. “People are doing research in this area, but you certainly hear a lot of anecdotal stories about patients who were enrolled in hospice and died 1 or 2 days later. The question is how to help people be more willing to accept that sort of care or be open to that discussion at earlier points.”

Health-care–assisted end of life is another area of controversy, Griebling added, noting that the federal government seems willing to leave this to the states at this point. “This is certainly an issue facing aging and geriatrics,” he added. “Going forward, I think it will be a matter of great debate as to how we handle end-of-life care both for younger patients with terminal illness and for older adults in general.”

For further reading


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