

# Medical Never-Never Land

Ten Reasons Why America is Not Ready for the Coming Age Boom



Alliance for  
Aging Research



## Acknowledgments

The Alliance for Aging Research is grateful to all who assisted in the preparation of this report. In particular we wish to thank Mr. Gerald A. Reed, an independent consultant in government relations and health care policy, and Mr. Paul DelPonte and his firm Hyde Park Communications for their help.

Several prominent national experts in gerontology and geriatrics agreed to provide input and review of this report. They include: Richard Besdine M.D., FACP, Brown University Center for Gerontology and Health Care Research; Elizabeth Bragg Ph.D., RN, Institute for Health Policy and Health Services Research, University of Cincinnati; Robert N. Butler M.D., International Longevity Center; William Hazzard M.D., University of Washington School of Medicine; Jerome Kowal M.D., Louis Stokes Veterans Medical Center; David Reuben M.D., UCLA Department of Medicine; Judith A. Salerno M.D., National Institute on Aging; John F. Santos Ph.D., former Director, Center for Geriatological Education, Research, and Services, Professor Emeritus University of Notre Dame; and Gregg Warshaw M.D., University of Cincinnati School of Medicine.

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*This report was made possible through a grant from the Retirement Research Foundation.*

# Foreword

Today, February 27, 2002, nearly 6,000 Americans will celebrate a 65th birthday. Ten years from today, the U.S. will have nearly *10,000 people a day* turning age 65. And still, too few doctors, nurses, psychologists, social workers and other health professionals receive any formal training in how to provide the best care for older patients. This disturbing fact has been highlighted by numerous studies and organizations over the past two decades, yet only modest progress has been made — even that may be lost in the next round of professional retirements.

We have less than 10 years before the huge first wave of Baby Boomers ignites a Senior Boom. If the U.S. fails to reform professional health education, equipping more providers with good geriatric health care techniques, we can't be surprised with the consequences. It will be a crisis that was a long time in coming and with plenty of warning. There will be no easy excuses.

This is the Alliance's third report to the nation on the shortage of health professionals trained to care for the nation's older patients. This study, however, is different from the earlier reports in three fundamental ways.

- This report focuses on the health professions team, not on physicians or geriatricians only. Appropriate care of the elderly requires a team of health professionals. The shortages we document are equally severe in nursing, pharmacy, social work, and indeed all the allied health professions.
- By no means do we say that every elderly individual should receive care from a geriatric specialist. We do, however, suggest that every health care provider who treats elderly patients requires some specialized training.
- Time is running out. Baby Boomers, who begin to turn 65 in a decade, will make a serious problem today practically impossible to solve in a few years.

This report identifies 10 reasons why our nation has not yet addressed this critical issue. Behind these barriers are three inconvertible facts:

- The numbers of older Americans have never been greater, and are about to soar.
- The numbers of health professionals with some formal training in caring for the elderly are woefully inadequate even for today's population.
- The American people expect this problem to be fixed for themselves and their families. A recent survey conducted for the Alliance by Opinion Research Corporation shows that three out of every four Americans feel it is very important that their healthcare providers have some specific training to care for the elderly.

Our newest report is intended to bring greater national attention to this subject. *Medical Never-Never Land* describes a problem, offers recommendations, and calls upon the nation's political and medical leadership to become engaged in shaping solutions.

Daniel Perry  
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February, 2002

## Executive Summary

In the new Disney movie *Return to Never Land*, Peter Pan journeys back to London after an absence of many years to find that Wendy is grown up and has children of her own. For everyone not on the island of Never-Never Land, aging is a fact of life that even Disney can admit. That much of American life and culture denies the reality of aging may be amusing. But when it comes to health care, the consequences of age denial can be downright dangerous.

More than 20 years ago the eminent geriatrician and author Dr. Robert N. Butler coined the term “Peter Pan Medicine” to describe age-denial in healthcare and medical education in the U. S. Training doctors and nurses to treat one disease at a time in otherwise healthy and resilient patients is relatively easy, he explained. But as adults grow older, there are complications and changes —

physiological, psychological and social — that require specialized training to provide the best possible care and most desirable health outcome.

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Unfortunately, very few health professionals in the U.S. — physicians, nurses, psychologists, pharmacists, physical and occupational therapists, social workers — have been exposed to the techniques and knowledge of geriatric health care as part of their professional training.

This creates a dangerous “disconnect” between the education of America’s health care providers and the aging of the population at large, and especially their patients.

Unlike the fictional Peter Pan, the U.S. is getting older. In less than a decade, the first members of the Baby Boom generation will reach age 65, and older people will grow steadily as a percentage of the U.S. population for the next several decades. Older Americans will more than double in number from 35 million today to 70 million by year 2030. Already, some 6,000 Americans turn age 65 every day in our country. In just 10 years, the number reaching that personal milestone will rise to about 10,000 Americans *each day*. As hard as it may be for some to

admit, the very icons of American youth and the Baby Boom generation soon will become part of the largest Medicare generation in history. Yet, our healthcare providers engaged in the delivery of care to the elderly are woefully under-prepared to meet this demographic sea change.



Older people have medical needs different from younger adults. The average 75-year-old person has three chronic medical conditions and regularly uses about five prescription drugs, as well as multiple over-the-counter remedies. In many instances older people are using 12 prescription drugs or even more at any given time. Changes with aging can alter how the body metabolizes, absorbs and clears these drugs from the body. Also, symptoms of illness can present differently in older people than in the young or middle-aged.

For many older people, chronic age-related conditions such as memory loss, depression, or incontinence, pose a direct threat to their ability to live independently. Careful management of these conditions by a multi-disciplinary team becomes paramount to maintaining long-term health, vigor and the capacity for personal growth and independence. Often the key to effective management of the complex and over-lapping health challenges of older patients is a health care professional who has at least some training and orientation in geriatric health care.

Just as Peter Pan hoped to never grow up, part of the collective American psychology does not want to acknowledge aging on a personal level. This is part of the reason we have created a Medical Never-Never Land: denying the graying of the population seeking health care, and blind to the need to train all health providers in age-appropriate medical techniques. Every older person should expect that his or her health care providers—social workers, nurses, pharmacists, physicians and other professionals—be trained to diagnose and treat their special needs. Despite decades of warnings from policymakers, physicians, social scientists and advocates, an acute shortage of geriatricians and health professionals with geriatric training persists in the United States.

Perhaps even more troublesome, the nation is without enough geriatric academic schools of medicine, nursing and the allied professions to educate the generation of health care professionals currently being trained. At a time when geriatrics and health promotion for older people should be infused into the training of all health professionals, this remains a distant goal. The nation is left with a very real geriatric gap that could overwhelm the health system, increase premature death and disability, and increase the costs of health care.

It is estimated that the U.S. currently needs 20,000 physician-geriatricians to care adequately care for our population of 35 million older people. Yet of the 650,000 licensed physicians practicing in the U.S., fewer than 9,000 physicians have met the qualifying criteria in geriatrics. Furthermore, this number is projected to decrease to as few as 6,100 by 2004. The U.S. will fall far short of the 36,000 geriatricians needed by 2030 unless effective steps are taken to train new providers. Many non-physician health professions are just as far behind.

It is estimated that the U.S. currently needs 2,400 geriatric academicians to train new providers, integrate geriatrics into medical practice, and develop standards of care for older people. However, there are currently fewer than 600 academic geriatricians in the U.S., and only a handful of medical schools require students to take any geriatric courses. The same holds true in dentistry, nursing, pharmacy, and other health professions.

The human benefits of improving the health and independence of older people are obvious. The financial benefits are enormous. If proper geriatric care resulted in a conservative reduction of hospital, nursing home and home care costs of just 10 percent a year, the nation would have saved \$50.4 billion in health care costs in the year 2000. The potential savings by the year 2020 of such a modest reduction would be \$267.4 billion in that year alone. Beyond direct savings in health costs, a healthier



more independent older population would contribute immeasurably to the nation by easing the cost growth of Medicare, Medicaid, and Social Security and by decreasing the need for nursing home and long-term care.

Significant, but still inadequate, research dollars are directed at serious conditions, such as Alzheimer's disease. But we may be falling further behind in support for research aimed at less dramatic but critically important conditions of aging that prevent older people from performing daily activities of living. Small reductions in the prevalence of falls or incontinence could extend the independence and activity of many older Americans and realize billions of dollars in health care savings.

Bridging the geriatrics gap in American medical education and practice will take leadership, resources and national will. A starting point is examining what factors have blocked our way until now. This report focuses on 10 reasons America's health professionals are not being adequately prepared for the coming Age Boom. Recognizing and addressing these barriers is the key to escaping from Medical Never-Never Land:

- Age Denial
- Older Patients Marginalized
- Lack of Public Awareness of the Geriatrics Gap
- Scarcity of Academic Leaders
- Lack of Academic Infrastructure in Geriatrics
- Geriatric Medicine Not Valued
- Inadequate Reimbursement
- Lack of Coordination within Medicine
- Clinical Trials Do Not Include the Aged
- Little Research on the Aging Process

Little time remains to overcome these 10 barriers before the Baby Boom becomes the Age Boom of the early 21st Century. The U.S. must take immediate steps to develop properly trained medical professionals to manage the care of older people. The most immediate need is to increase the number of qualified academic leaders to train the next generation of providers. Greater numbers of primary care physicians, pharmacists, psychologists, nurses, social workers, and other providers must receive formal training in geriatrics, and specialists who treat large numbers of

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A blue-tinted photograph showing a female doctor in a white lab coat with a stethoscope around her neck, leaning over to examine an elderly woman. The elderly woman is seated and looking towards the doctor. The background is slightly blurred, suggesting a clinical setting.

By 2030, the U.S. will need up to 36,000 geriatricians and will fall far short of that figure by as many as 25,000 unless effective steps are taken to train new providers.



older people must receive geriatric certification. Students in virtually every health field must receive geriatric training as part of their course work, residency training and field placement.

America has run through its reasons for staying mired in Medical Never-Never Land — there are no good excuses left. Aging is not a statistical abstraction. It is a reality driving the future of health care in America. Evidence already shows that a lack of geriatrics-trained health professionals and standards of care is eroding the quality of health care afforded older Americans. For example, a recent article in *The Journal of the American Medical Association* focused on the widespread inappropriate medication use among the elderly.

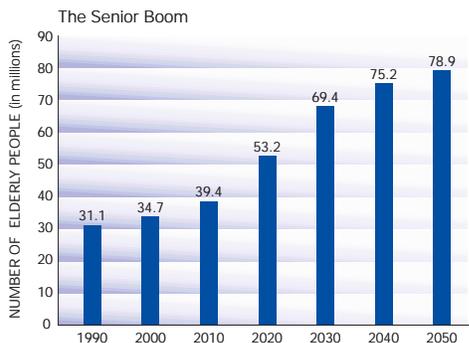
Unless action is taken soon, this geriatric disparity will widen as older people increase in number and as a share of U.S. population. America must end this shortage of geriatrics-trained health professionals, and the academic leaders needed to train them, or remain trapped in Medical Never-Never Land, where the appropriate care needs of older people are unmet and the consequences possibly tragic.



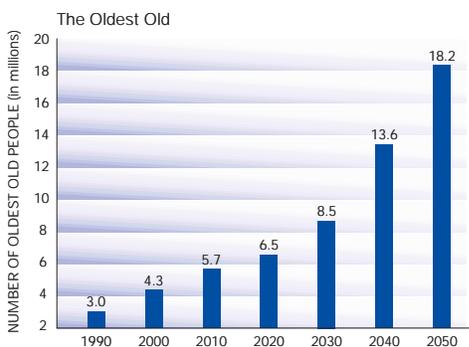
A 77 year old man in good health noted breathlessness for a day or two then collapsed from what appeared to be a massive stroke. He was taken to a hospital where he was treated by doctors without special age-related training. The man did poorly and became, essentially unresponsive. He was put on large doses of medication to block acid production in his stomach and the potential of stress related gastric ulcer bleeding. He ate little and a feeding tube was placed. He continued to do poorly and was transferred to a nursing home where family felt he would die. In the nursing home, the geriatrician noticed that his mental status was fluctuating, more consistent with delirium, a reversible condition, than a stroke. The geriatrician discovered that the patient's earlier heart failure had been too aggressively treated and that the patient was dehydrated. From the high doses of the ulcer preventive medication, drug toxicity developed. The medication was discontinued and fluids were administered. The patient improved and eventually, the feeding gastrostomy tube was removed; a Foley catheter, which had been placed to collect the urine, was removed and the patient ultimately was able to eat and eventually go home and ambulate slowly. After several months he had only partial dependencies. Often delirium is missed by physicians with no geriatric training with potentially adverse outcomes.

## The Demographic Imperative

The American population is getting older. Every day in the U.S. some 6,000 people celebrate their 65th birthday. In less than a decade nearly 10,000 a day will reach that milestone. By the year 2020 there will be 50 million older Americans, and 70 million by 2030. Then almost one in every four Americans will be over age 65. This shift will affect every part of society and life: from work to leisure, transportation to housing, and from corporate strategies to family relationships. The graying of America will have its most dramatic consequences on health care. Older Americans, currently 13% of the U.S. population, account for 36% of hospital stays, 49% of all days of hospital care, and 50% of all physician hours. In the foreseeable future, older Americans will account for half of all health care expenditures.



Longevity can be a blessing and most people are grateful for longer lives. More Americans are celebrating their 75th birthdays, their 85th birthdays, and their 100th birthdays. Those over age 85 years—the oldest of the old—will increase from 4 million today, to nearly 19 million by 2050. This group will include more than 1 million centenarians.



## The Medical and Social Necessity

The seismic shift in demographics alone should warrant greater medical focus in geriatrics. New medical challenges that come with the age-wave present compelling reasons to adjust health education and practice. While a healthy youth is often a good predictor of a healthy older person, longevity often increases the complexity of a person's medical and social needs. On average, people age 75 years or 80 years have more ailments and often more multiple ailments than people age 65 years. The average 75-year-old person experiences three chronic conditions at any given time. Some report as many as 10. The average person at age 75 years uses more than 4.5 prescription medications at any given time. More than one in four people at age 75 years report at least one disabling condition. At age 80 years, three out of four people report a disabling condition. In addition, age-related social and psychological factors, such as retirement, widowhood, bereavement and isolation, can compound the health care challenge for older adults.

Health care professionals not only will be treating more older patients, they will see far greater incidence of the diseases that affect older people, such as dementia, cancer, bone and joint diseases, and vision impairment. The incidence of many illnesses rises with age. For example, there are a greater percentage of men with prostate cancer at age 85 years than at age 75 years, according to the Mayo Clinic. The number of people with Alzheimer's disease is expected to double from approximately 4 million today, to more than 8 million by 2020, and could reach 14 million by 2040. The Centers for Disease Control and Prevention (CDC) estimates that arthritis will affect more than 60 million Americans in 2020 and limit the daily activities of nearly 12 million.

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There will be a rise in diseases that affect older people, and in the medical conditions associated with older age. The number of hospitalizations for hip fractures in people age 65 years and older rose from 230,000 in 1988 to



340,000 in 1996. The number is expected to reach more than 500,000 per year by 2040, according to the CDC.

Nearly all geriatric hip fractures are fall-related. Each year, approximately one in three people age 65 years or

older experiences a fall-related injury. Of these people, approximately 20 to 30 percent suffer a reduction in mobility and independence. Half of all people hospitalized for hip fractures cannot live independently after their injuries. In the U.S., women sustain approximately 80 percent of all hip fractures. Osteoporosis-related fractures are the most common fall-related injuries in persons over age 65 years.

Older people experience conditions associated with advancing age, such as hearing loss, vision loss, loss of bone density, loss of mobility, and other age-related functional declines that hinder ability to perform activities of daily living. Many of the conditions associated with age, such as memory loss and loss of cognition also mimic the symptoms associated with serious illness. These symptoms manifest differently in older people and medical professionals must be trained to distinguish what is disease and what is not.

Older people have two goals in their health management. The first goal, like that of young people, is to prevent illness and maintain good health. The second is to manage the changes associated with aging, sometimes managing degrees of disability, in order to prolong their independence and activity. Too many older people fail to distinguish between these two goals. A medical workforce lacking in geriatric training will also lack the training to help the older population differentiate between aging related health promotion and disease prevention and suggest the necessary health strategies that will preserve independence.

Too many older people are conditioned to accept as inevitable the decline that accompanies aging. More troubling is that too many health professionals unfamiliar with geriatrics, perpetuate this notion. Conditions that can be treated, such as loss of cognitive function or

incontinence, often are viewed as the first step to inevitable decline and institutionalization. This need not be the case. Memory and other cognitive losses can be improved, or their declines slowed, through appropriate pharmaceutical and non-pharmaceutical interventions. Incontinence is a significant contributing factor to the loss of independence, affecting nearly 50 percent of people in nursing homes. Yet, many types of incontinence can be treated, delayed or managed with low-cost and non-embarrassing methods that empower older people to maintain active, public lives.

### Different Diseases/Different Conditions

Changes in the body that accompany the aging process complicate the diagnosis and treatment of many diseases. The fact that many older people experience more than one chronic condition complicates the diagnosis of their other health problems. Depression is now considered a common illness among older people, yet it is under-diagnosed and under-treated. Often, it is confused with the onset of cognitive impairment, which affects 5 to 15 percent of people over age 65 years and approximately 40 percent of people age 85 years or older. However, the cause of depression can often be something as simple as hearing loss, which affects one-third of people age 65 years, two-thirds of persons over age 70, and three out of four people over age 80 years.

Geriatric training and treatment targets these often-complex overlapping factors. Like peeling an onion, the geriatric approach helps move through each layer of health and social issues impacting the well being of a patient. Geriatric assessments are often interdisciplinary encounters, requiring physicians, psychologists, nurses, and other members of the health team to assess physical and emotional states, as well as living arrangements, which can accelerate physical and mental decline. Also, the care of older people can vary greatly from that of younger people. Caregivers, such as family members, friends, and neighbors, are often called to play crucial roles in maintaining the independence of older people. Care must often be coordinated between the geriatric trained specialist and several providers, such as primary care physicians or cardiac specialists. Geriatric specialists, who are trained to foster cooperative team care, are needed in every aspect of the care of older people, from physicians to social workers.

**M**rs. H is a 94 year-old African-American female who lost her balance and broke her hip in April, 2000. Until that time, she cared for herself in a two-story townhouse she had lived in for 50 years. She had cooked her own meals, including Thanksgiving family dinners, and enjoyed her favorite television shows.

Mrs. H was hospitalized for the broken hip and surgeons, who had not received any specific geriatric training, recommended bedrest for 8-10 weeks. The results were catastrophic. She suffered from bedsores, confusion, and bladder infections after spending three months in a hospital and nursing home. The bedrest weakened her muscles, so her knees could no longer bend, and she became permanently bedbound.

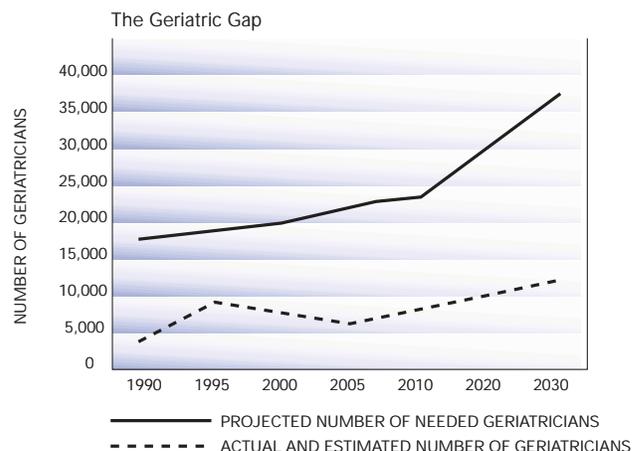
When she returned home in August 2000, her daughter, Mary, moved in to care for her on a 24-hour basis. The “den” off the kitchen became a studio apartment, where a hospital bed used up half the floor space. Care is extensive, and the daughter’s only relief is when a home health aide comes each day for four hours. Wounds must be dressed, in addition to all other daily physical functions and feeding. In February 2001, her family decided to enroll her in a house call geriatric care program.

During the next eight months, Mrs. H. had several medical issues which were handled by the geriatric professionals without any trips to the emergency room or doctor’s office. In time, the geriatric care healed her bed sores, urinary tract infections, and pneumonia. Her medications were reduced, both improving her mental status and allowing her to finally converse with her family once again.

## The Geriatrics Gap

Despite a general consensus that a core group of trained geriatricians is necessary to maintain the health and functioning of older people, a critical shortage of geriatric trained professionals persists in the United States. There are currently only 9,000 physicians with geriatric certification in the U.S. However, the U.S needs 20,000 to provide adequate treatment to its older population. The Alliance for Aging Research estimates the U.S. will need approximately 36,000 geriatricians to treat 70 million older people by the year 2030. Unless a significant commitment is made to geriatric medical education, the U.S. will fall short of this projection by as many as 25,000 doctors. In addition, many of the nation’s 650,000 physicians in current practice will require continuing education with significant infusions of geriatric training.

This geriatrics gap applies not only to physicians, but also to virtually every field of health care. Less than one percent of nurses in the U.S. are certified in geriatrics and only three percent of advance practice nurses specialize in the care of older people. Less than *one-third of one percent* of physical therapists is board certified as a geriatric clinical specialist. Of nearly 200,000 pharmacists in the U.S., only 720 have geriatric certifications, in spite of the fact that the elderly are by far the largest users of pharmaceutical products.

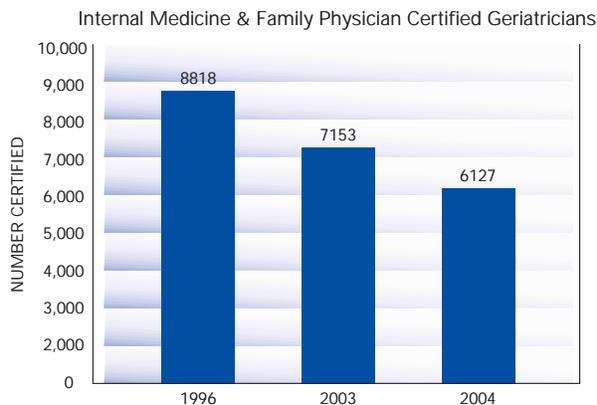


Compounding the gap is an acute shortage of academic leadership to expose all U.S. health providers to geriatric content as part of their professional training. Academic geriatricians are needed to provide training, guidance, and role models, yet the U.S. has fewer than 600 medical school faculty that list geriatrics as their specialty—out of a total of 100,000 faculty members. Academic geriatricians are needed to conduct research on the conditions of aging. Geriatricians comprise approximately 0.5 percent of all medical educators in the U.S., representing the largest educational training gap in any field. This shortage dwarfs the lack of other educational shortages, including the low number of primary and secondary school math and science teachers.

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**The Gap is Widening**

Though some progress has been made over the past decade, we are likely to lose ground in the coming years. The Association of Directors of Geriatric Academic



Programs (ADGAP) has projected that the number of certified geriatricians would actually fall to near 6,100 by 2004 because the number of certified geriatricians not seeking re-certification is greater than young physicians completing their geriatric fellowships. The shortage reflected in the ratio of providers to patients is expected to increase further as the size of the older population grows. It is currently projected the U.S. will have only one-fourth the geriatricians needed to care for older people as the growth of the Baby Boom generation reaches its crest.

This applies to all health-related disciplines. According to the John A. Hartford Foundation, “The rate of increase in geriatrics training and research capacity in the nation’s medical, nursing, and other health professions’ schools continues to lag far behind need; indeed the number of geriatricians appears to be diminishing. At every level (undergraduate, graduate, post-graduate) and in every sphere (medicine, nursing, physical/occupational and other therapies, social work, pharmacology, etc.) of health professions education, the gap between need and supply is widening.”



By no means does every older person have to be treated by a geriatrician, simply due to age. However, every physician, psychologist, pharmacist, nurse, physical therapist, or social worker that treats older people should have some training in geriatrics. Geriatricians are needed for consultations on difficult cases and to develop curricula for professional schools and standards of care for the treatment of older people. A critical mass is needed to stimulate the field and to permeate proper medical care. However, the current ratio of approximately 2.5 geriatricians to every 10,000 elderly patients is insufficient to meet these most basic needs.

If geriatrics does not penetrate the curricula of American medical schools, it will not permeate mainstream medical practice. Without the leadership of medical schools, the U.S. cannot create the core group of providers needed to care for older people. And while it is not necessary that every provider treating older patients be a geriatrician specialist, it is necessary for providers to understand the logic, goals, and some of the techniques of good geriatric care. For example, one study has shown that exposing providers to the principles of communicating with geriatric populations improves the health outcomes of older patients.

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There are good models to follow. Great Britain maintains a full-time Department of Geriatrics at nearly every medical school. Japan has full departments of geriatrics in half of their schools of medicine. In the U.S. only three departments exist out of 144 medical schools. A good case can be made that strong divisions of geriatrics and adult

care within departments of medicine and its sub-specialties, as well as nursing and other fields, is also an effective way to create critical mass towards improvement.

Without a consistent and persistent effort to integrate geriatrics into U.S. health professional education and to develop academic leadership, America will remain stuck in its Medical Never-Never Land. The shortfall in

geriatricians training will perpetuate itself. If fewer medical students are exposed to geriatrics, there will be fewer geriatricians to assume academic teaching posts. If there are fewer geriatric academicians to train new professionals, there will be fewer professionals in all disciplines to meet the special needs of older patients.

### A Crisis That Is Already Here

Beginning in 2011, the largest generation ever in America will begin to move onto the rolls of Social Security and Medicare. This will exacerbate any problems not addressed earlier regarding the health outlook for older people. There is ample evidence that the geriatrics gap among American health professionals already is undermining the health outcomes of older Americans.

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If more consistent and widely available geriatric care could result in a reduction of hospital, nursing home and home care costs by just 10 percent a year—a reasonable and realistic public health goal—the U.S. could have saved \$50.4 billion in the year 2000.



### Human Costs

Researchers estimate that medication problems are involved in as many as 17 percent of all hospitalizations of older people and that 35 percent of people over 65 experience adverse drug reactions. A study published in

the December 12, 2001 *Journal of the American Medical Association* shows more than one out of every five older patients receive prescriptions of inappropriate drugs. Worse, physicians are often reluctant to prescribe chemotherapy or cardiac drugs to older people because they mistakenly believe the benefits will not outweigh the pains of treatment. Yet, studies indicate many older people benefit from such treatment as well as or better than younger patients. Just one example:

William Bergman, an 85-year-old Californian was denied pain medication in the final stages of lung cancer because his physician was reluctant to prescribe addictive drugs. His case led to changes in California law requiring physicians to take classes in both pain management and

end of life care. Mr. Bergman is not alone. A study in the June 2001 *Gerontologist* suggests, "Pain is prevalent and often goes untreated in nursing homes."

The marginalization of a patient on the basis of age undermines the care of older people. Physicians who would not hesitate to prescribe exercise regimens, smoking cessation programs, or cholesterol lowering strategies to 45-year-old patients, often hesitate to prescribe such therapies to older patients, though evi-

dence shows they would benefit. Advancing age reinforces this disparity in treatment. Studies suggest people age 65 years are far more likely to receive cholesterol lowering drugs than people age 75 years. There is a well-documented tendency for physicians to under-prescribe blood thinners, beta-blockers, ACE inhibitors and other cardiovascular drugs to older patients after coronary incidents.

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### Cost in Dollars

This inability to guarantee effective standards of care not only undercuts the health and independence of older people, but also increases the costs of caring for older Americans. This accelerates Medicare costs and affects the economic health of all Americans. If more consistent and widely available geriatric care could result in a reduction of hospital, nursing home and home care costs by just 10 percent a year—a reasonable and realistic public health goal—the U.S. would have saved \$50.4 billion in the year 2000.

There are numerous economic benefits to delaying the illnesses associated with aging and prolonging the functional activity and independence of older people. The U.S. realizes \$5 billion in savings for every month that the physical independence of older people is extended. According to the CDC and The Center for Bladder Control, decreasing the prevalence of incontinence and fall-related injuries by 5% could generate more than \$1.6 billion savings for direct health care costs, which could easily reach \$40 billion by 2020. Even greater savings are realized by reducing the number of people in long-term or nursing home care.





## 10 Reasons America is Stuck in Medical Never-Never Land

The following barriers — cultural, educational, economic and political — help explain why the U.S. has not moved sooner to integrate geriatrics and age-appropriate professional training at every level of the American health care system. Knowing these inhibitions and excuses is the first step to overcoming them. When the Baby Boom generation begins moving past age 65 at a rapid rate in less than a decade, there will be no room for more excuses.

In the few years before that happens, the U.S. must address and reverse the reasons for our past complacency and inaction. It is time to confront our attitudes toward aging and the structural changes in both health care education and medical research that have kept us in Medical Never-Never Land.

### 1. Age Denial

On both an individual and a national level, we have not owned up to the fact that we are aging. Those in the Baby Boomer generation still think of themselves as youthful, and the U.S. still thinks of itself as a nation of young pioneers, rather than facing the fact our population is aging with unprecedented size and speed. Age denial is at the root of the failure to address the gap in geriatric training.

Americans also tend to deny existence of problems that can accompany aging. There is a stigma attached to discussions of many health issues associated with older age such as incontinence or memory loss. Yet, such health problems cause a significant number of nursing home admissions each year, compound hospital stays, lead to inappropriate use of medications and increase the risk of medical errors.

### 2. Older Patients Marginalized

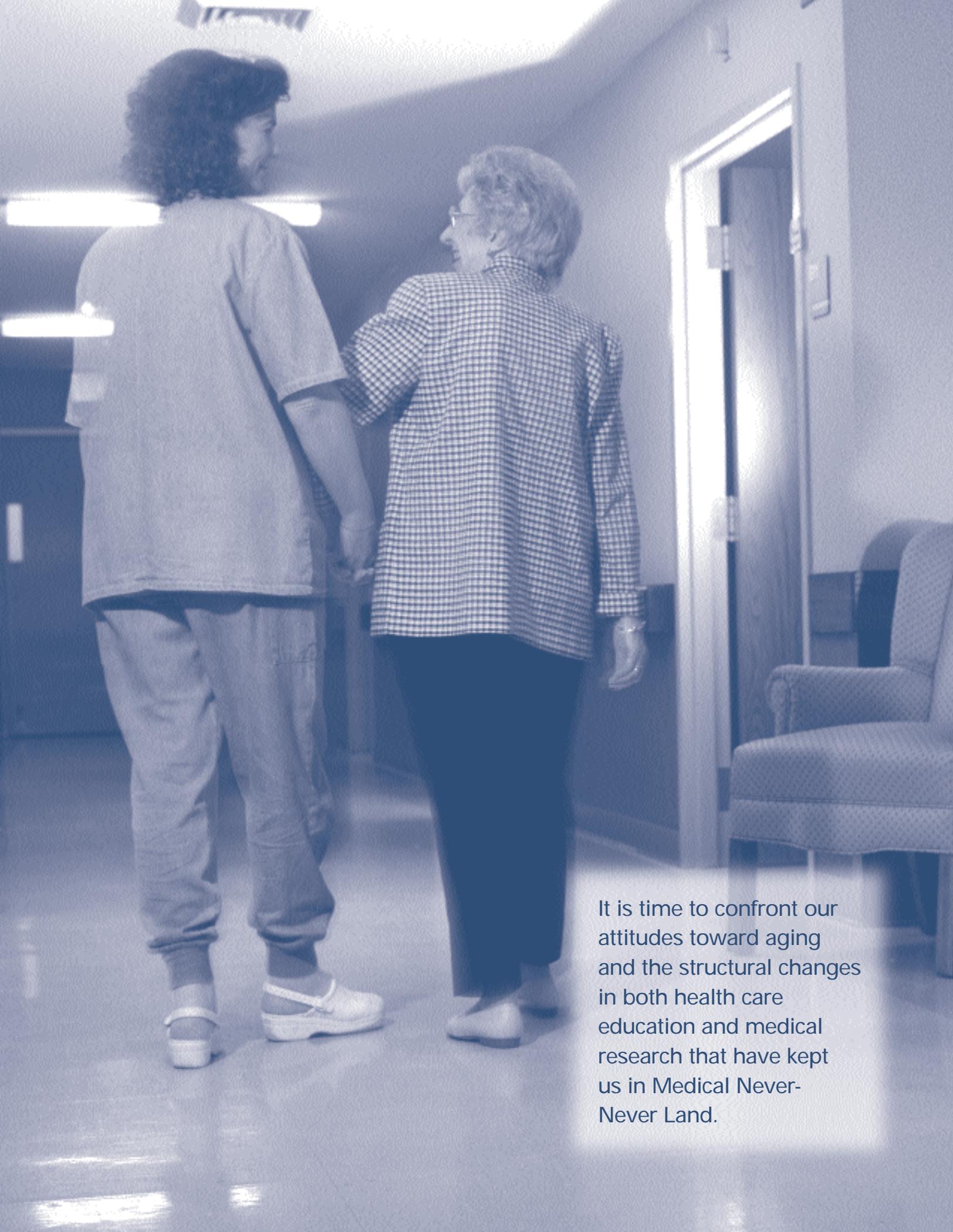
Older patients are seen as nearing the end of life and with smaller chances of recovery than younger patients. Prevention programs have a youth focus and offer little to help older people increase their health or independence. This is too often based on age-related biases and improper understanding of the health status and medical condition of older people. Pure and simple, this is a case of ageism.

Older patients confront a prejudice prevalent throughout the health care system that decline is inevitable. As a result, there is little effort to redress the problems facing older patients. For example, potential barriers of culture, age, hearing loss, or expediency can often confuse communications between young providers and older patients. Since most providers lack the grounding in geriatric principles needed to understand these barriers, they perpetuate stereotypes that marginalize older people as difficult to manage or treat, or, worse, destined for decline.

### 3. Lack of Public Awareness of the Geriatrics Gap

The general public is unaware that most of their health care providers have never had any specific formal training in how to care for elderly patients. Many older people are not aware that their doctors, pharmacists, or nurse practitioners overseeing their care have never had this training. This lack of awareness prevents a critical mass of public opinion from forming around this issue.

Yet when made aware of this gap in training, Americans overwhelmingly want their providers to get the necessary training. A survey conducted for the Alliance for Aging Research by Opinion Research Corporation in February 2002 found that 74% of all Americans feel it is “very important” that their healthcare providers have some aging-specific training. The number jumps to 96% when those who believe the need for specific training is “some-what important” are included.



It is time to confront our attitudes toward aging and the structural changes in both health care education and medical research that have kept us in Medical Never-Never Land.



#### 4. Scarcity of Academic Leaders

Too few academic leaders in American schools of medicine, nursing, and other health professions are present to integrate geriatrics into professional health education. The drive to initiate change in medical practice often begins in academia. Academic leadership is necessary to propel an issue to prominence within the health professions and creates the infrastructure for training new

providers. There are too few academic leaders focusing their careers on the needs of older people in all fields of health care and social research.

Of the few physicians, for example, who specialize in academic geriatrics, most are required to devote more than half of their time to direct patient care because there are too few geriatricians. As a result, too few geriatricians dedicate their time to researching the care of older people and training students. This creates a

ripple effect throughout the medical education system. There are too few academicians to define and articulate the health needs of older people; and too few academics to facilitate the transfer of research findings into practice.

#### 5. Lack of Academic Infrastructure in Geriatrics

The simple fact is that while health care providers will spend much of their time caring for older patients, there is often no required rotation in geriatrics. While this has improved very recently thanks to investments in geriatrics infrastructure by a few private foundations, over half of all medical schools still have not appropriately broadened their curricula.

The current infrastructure used to train student physicians at most medical schools does not adequately fit the geriatric model. Less than three percent of U.S. medical students opt to take an elective in geriatrics. This, to a large degree, can be traced to the lack of established geriatric teaching units within professional schools, and lack of academic role models. The one-month training rotations some residents receive do not permit future providers to adequately experience and understand how

geriatric practice improves health and independence over time. Brief and transitory exposure to sick older patients in hospital wards without this follow-through perpetuates the stereotype that older patients are hopeless cases destined for decline.

#### 6. Geriatric Medicine Not Valued

Geriatric medicine lacks the prestige and financial rewards afforded other fields of medicine. Older patients are perceived as more difficult to diagnose and treat. Geriatrics does not rely on high-tech procedural medicine or dramatic cures as much as other disciplines, which leads to lower levels of reimbursement and relatively less career glamour compared to other medical fields. This is further hampered by a lack of medical role models and investment in geriatrics education.

Limits on the number of residency slots funded by Medicare also discriminate on new fields like geriatrics. Only 450 of the 98,000 academic fellowships funded by Medicare education funds are in geriatrics. Put another way, the very program designed to treat older Americans devotes less than one-half of one percent of its training dollars to programs specifically aimed at treating older Americans.

#### 7. Inadequate Reimbursement

Medicare and other health care insurers provide higher reimbursement for procedures, tests, and technology-driven medical care that are not the core of geriatric care. Also, good geriatric care runs counter to trends shaping health care practice, such as physicians spending fewer minutes with each patient. The appropriate time required for an average office or home visit for an older person, who often has multiple health problems, is longer than that for a younger patient. Reimbursement does not adequately reflect this added provider time. This skew reduces the incentives for providers to seek certification in geriatric practice.

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Cost-saving measures by Medicare and other insurers often demand that health care providers, including physicians, pharmacists, and therapists receive decreasing reimbursement rates for patient visits. Providers are expected to compensate for

loss of income by seeing more patients in less time. The diagnostic tools that allow professionals to reduce time spent with patients often cannot effectively discern the health status of older patients. For example, a sudden shift in behavior could be caused by a loss of hearing, numerous metabolic conditions, the first signs of dementia, or a reaction to medications. No single test could isolate each of these possible causes.

### 8. Lack of Coordination within Medicine

There are tremendous resources separately focusing on illnesses, such as cancer, arthritis or heart disease, that primarily affect older people. However, these resources often operate in separate silos, missing valuable opportunities to better understand, prevent, treat and cure these illnesses, or to provide proper rehabilitation in older people.

While specialization and compartmentalization are the increasing norms of health care, they often do not fit the needs of the elderly. Older people often have several chronic conditions at the same time requiring more than one specialist. One elderly woman asking her oncologist about painful muscle stiffness was told, “That is not associated with the condition I treat. Ask someone else.” Cardiovascular, neurological, and other conditions are part of the aging process. The health and independence of older people depends not only on how well they manage each condition, but how they co-manage all these conditions.

Older people require a team approach to care — a team that understands medical conditions in the context of aging — a team that understands how conditions such as depression or loss of mobility influence the course of illnesses such as hypertension or heart disease. Isolating the treatment of arthritis from the treatment of heart disease inhibits understanding of how the effects of aging influence the overall health. The ability to prolong healthy activity and positive mental outlook influences the pro-

gression of illnesses, such as heart disease. There is insufficient effort by the health care community to integrate these concepts into the care of older people.

### 9. Clinical Trials Often Do Not Include the Aged

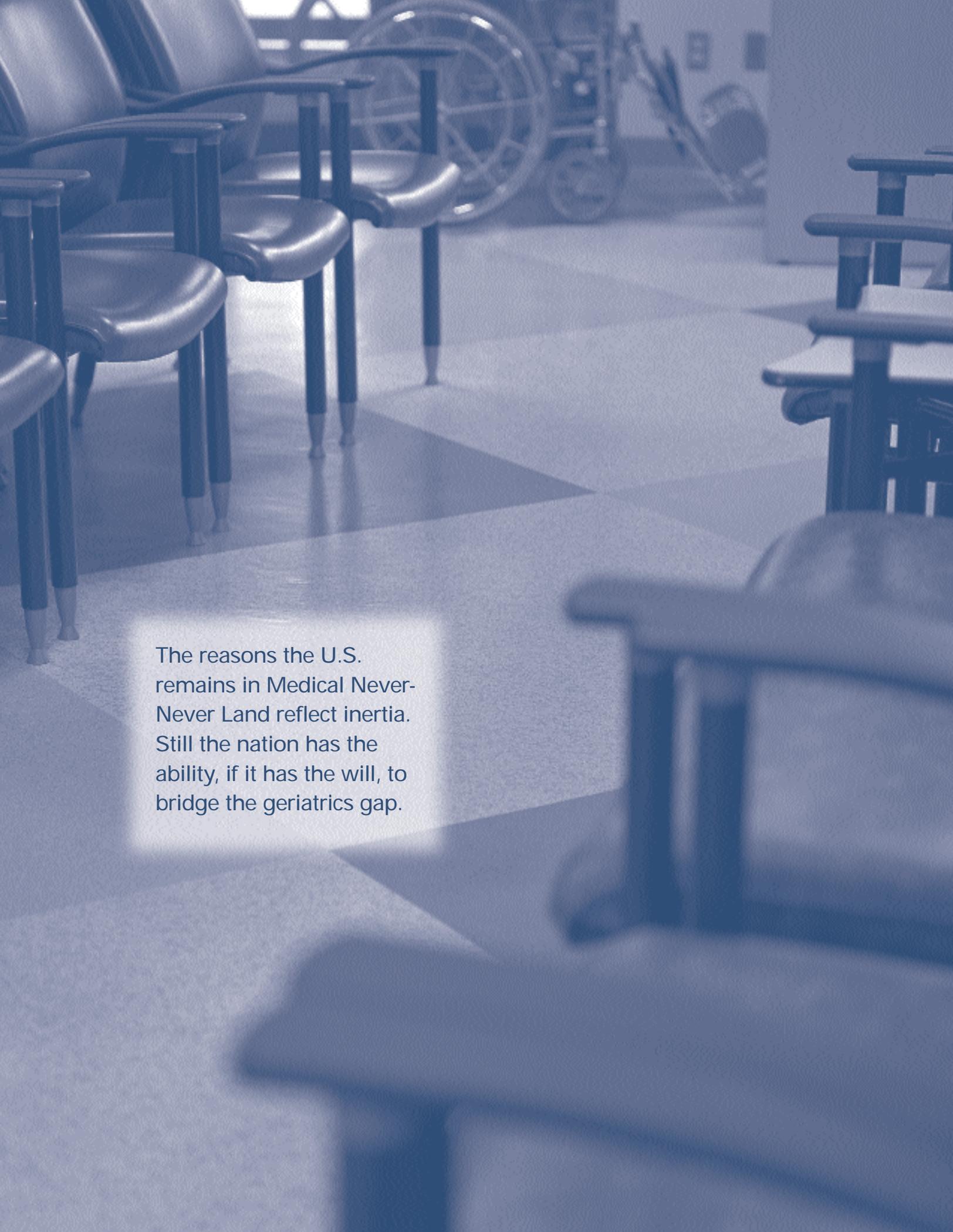
Pharmaceuticals are fast becoming the treatment of choice for many conditions of aging, but older people are under-represented in the clinical trials of many of these drugs, which complicates creation of safe standards regarding their use in older populations. It is especially rare for experimental drugs to be tested in populations of people age 75 and above with co-morbidities, though increasingly this is the largest group of consumers of pharmaceutical care in the U.S.

Until 1990, older people were routinely excluded from clinical trials. Despite efforts since then to enlist greater numbers of older patients in clinical trials, they remain vastly under-represented. Older women account for 49 percent of all breast cancer cases, yet they account for only nine percent of the study populations of clinical trials, according to a study in the *New England Journal of Medicine*.

### 10. Little Research on the Aging Process

Less than one percent of the entire budget of the National Institutes of Health (NIH) is devoted to studying the basic biology of aging. While tens of billions of dollars will be spent each year on the specific study of disease, little is invested in understanding how the single largest demographic fact of life will impact those illnesses. The lack of such attention greatly reduces the cross-fertilization that is necessary to build the fields of aging research and geriatrics.

There are significant resources dedicated to diseases that largely threaten older people — such as cancer, heart disease, diabetes, or respiratory diseases — but research programs in these areas often fail to focus on the specific role of the aging process in the incidence or course of the disease. As science is learning more about the aging at the cellular level, this research is not transferred to a broader understanding of the diseases of aging. Too few research dollars go to determine how chemical or metabolic changes, which occur between ages 65 and 80, shape the progression of illness.

A blue-tinted photograph of a waiting area. In the foreground, there are several rows of modern, dark-colored chairs with light-colored seats. In the background, a wheelchair is visible, and the floor is a light-colored, polished surface. The overall atmosphere is quiet and somewhat somber due to the monochromatic color scheme.

The reasons the U.S. remains in Medical Never-Never Land reflect inertia. Still the nation has the ability, if it has the will, to bridge the geriatrics gap.

## A National Will to Act

Due to the above 10 reasons, there is little resolve to address the shortage of geriatric providers in the U.S. Without national leadership and sustained public support, the U.S. will not adequately address this issue in time to prevent the gap from widening with serious consequences. It is possible this crisis will reach critical mass with tragic — and perhaps irreversible consequences — before America has the will to act. We urge the health professions themselves, educational institutions, foundations and policymakers to prevent this from happening. The U.S. must awaken to the shortfall in geriatric health professional training with the same urgency the nation now gives to protecting the financial solvency of Social Security and Medicare.

## Recommendations

The lack of geriatric training in the professions that govern the care and treatment of older people in the United States constitutes an immediate and continuing crisis. It is a crisis the U.S. should have addressed by now. However, the reasons the U.S. remains in Medical Never-Never Land reflect inertia. Still the nation has the ability, if it has the will, to bridge the geriatrics gap.

### End the Denial

Grown up Americans should realistically accept and plan for their own aging. As a nation we should accept there is an urgent need for more geriatricians and geriatrics educators in all fields of physical and mental health. The U.S. will only end its denial of aging by awakening to the urgent health needs of older people. A lack of geriatric professionals has already undermined the health of thousands of older people. A lack of awareness undermines the health of thousands more. Too many people wrongly regard any sign of forgetfulness in older people as the first step toward unstoppable dementia. Educating Americans to the true health needs of older people will propel this issue to the public agenda and create a demand for geriatric services that moves healthy policies to achieve corrective action.

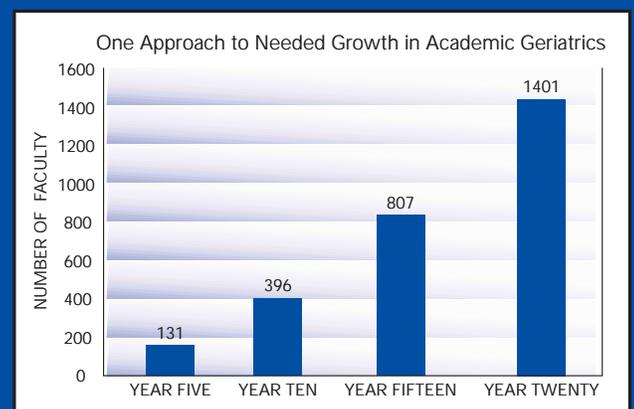
The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services is currently developing a report on the health workforce implications of an aging America. While this report is a good first step, it alone does not respond to the dramatic demographic shift American medicine is just beginning to experience. Changes are needed at the federal, state and local level to accelerate geriatric education in the healthcare professions.

The U.S. must awaken to the shortfall in geriatric health professional training with the same urgency the nation now gives to protecting the financial solvency of Social Security and Medicare.

### Develop Geriatric Leadership

The U.S. must set goals to increase the number of geriatric academics in all fields of the health sciences. These targets should be matched with adequate funds and

Dr. Robert Butler, the first director of the National Institute of Aging, has proposed an algorithm to closing the geriatric gap for academic physicians. Over a 20-year period, Butler would increase the number of medical schools training academic geriatricians through federal support — reaching all medical schools by the 15th year. His approach would produce a cumulative total of 1,400 academic geriatricians by the 20th year at a relatively modest average annual cost of 22 million dollars. And while Dr. Butler's plan is ambitious, it is barely enough to keep up with the population growth of the elderly. It would need to be augmented with private sector programs in order to adequately meet the need.



training resources to provide incentive for students. Improvements to the training infrastructure, including increasing the length of fellowship support and increasing geriatric research and teaching time, must be achieved.

The U.S. should fund geriatric research and centers for excellence to attract academicians to geriatrics. The nation should also dedicate a larger percentage of government research dollars to studying the basic biology and conditions of aging. This will generate interest in human aging and geriatrics at major universities and academic institutions. The government has created resources to develop geriatric leadership, such as the Claude Pepper Centers, the HRSA Geriatric Education Centers, and the Geriatric Education and Clinical Centers (GRECCs) of the Veterans Administration, but now must to support such efforts more fully and generously.

**Make Careers in Geriatric Care More Attractive**

The U.S. should set a goal of attracting new providers to geriatric practice, and commit programs to achieving the goal. Targeted financial incentives, such as loan forgiveness and continuing education funds, are needed across all health fields and specialties to encourage exposure to geriatrics and age-related care.

Proper age-related and geriatric medical care is the only direction our nation can take. The time to make this investment is now.

The income disparities between geriatricians and other specialties should be reduced. Loan forgiveness programs and other financial incentives are necessary to eliminate the financial burdens of paying for medical education, which can dissuade

young providers from entering geriatrics. Improved reimbursement from both Medicare and managed care organizations would help to transform geriatrics into viable career paths for prospective young health professionals.

**Integrate Geriatrics into Medical Education**

The drive to integrate geriatrics into the training infrastructure of health care providers will require government leadership and government funds. Geriatrics must be

infused throughout the U.S. medical school and teaching hospitals curricula. The federal government should require every health professional school, hospital, and teaching facility receiving government training dollars to require geriatric course



work or rotation. States, especially those with significant numbers of older people, should examine licensing requirements as they pertain to geriatric training and care.

**Provide Incentives to Include Older Patients in Pharmaceutical Trials**

The federal government should develop incentives for private industry to stimulate increased pharmaceutical research and testing among older people. Research and development tax credits, patent extension and labeling allowances should be explored to increase inclusion of older people in research on new drugs.

**Escape From Never-Never Land**

Considerable public policy attention in the coming months and years will focus on the financial solvency of Social Security and Medicare. These two programs represent vital support and necessary care to the nation's ever-growing, ever-changing older population. These are large and vital programs. Beyond policy changes, the outlook for protecting Social Security and Medicare becomes brighter if those two programs serve to increase the prospects for healthier, more vital and independent lives. Proper age-related and geriatric medical care is the only direction our nation can take. The time to make this investment is now.





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