Aging Issues are Intricate Issues
Health Care Systems and Services for Arizona

Most Americans and Arizonans believe everyone, including elders, should have access to high-quality, low-cost health care. As Bob Bulla, former CEO of Arizona Blue Cross/Blue Shield puts it: "People want whatever the doctor prescribes, and they want to pay $5 for it."[19] What's more, people want health services when, where and how they want them. Unfortunately, instant health care gratification is at odds with reality. Understanding more about health care now is vital to finding ways to ensure that supply and demand are in balance as Arizona has more and more elders.

A System in Name Only

Today's hospitals, nursing homes, physicians, home health agencies, supply and equipment manufacturers, drug companies, insurance companies, managed care organizations, surgicenters, hospices, nurses and other health care workers, administrators, marketers, lawyers, planners and research organizations all have a hand in health care delivery.[20] As comprehensive as this list seems, thousands of other, often nonprofit, organizations and countless professionals and volunteers supply case management, respite care, chore services, independent living centers, senior centers and health-related social services. The Central Arizona Community Information and Referral Directory alone lists scores of organizations in advocacy and health categories. The Pima Area Agency on Aging distributes an elder care directory for the southern part of the state. The most recent *County Business Patterns* from the U.S. Census Bureau tallies more than 9,000 Arizona "establishments"* in the health field with annual payrolls of more than $5 billion and over 167,000 employees.

Arizona's health care networks and community services, though, can hardly be called systems. Rather, they are an amalgam of providers, programs and services. In today's environment, it is tough to supply high-quality, low-cost health care to everyone who wants it. Sizeable subsidies from employers and governments mask the true costs of individuals' health care. In addition, whether they realize it or not, citizens view health care both as an individual right and a public good that should be universally available and affordable. Meanwhile, the bulk of providers are part of enterprises that see health care as a private good, which is available to those who are willing to pay for it.

Enormous, Endangered and Riddled with Contradictions

Most experts say that two out of the three goals of universal access, high quality and reasonable costs are possible at once, but not all three.[21] But finding palatable tradeoffs among perceived "rights" rates as risky as a high-wire act. The search for workable solutions has been an on-again, off-again policy exercise for years. As *Washington Post* journalist David Broder wrote recently, "The American system of medicine is threatened with a meltdown from a combination of rising costs, declining access and incredible inefficiencies. Throw in a batch of unresolved political differences and you have a mess that demands attention."[22]

Today four trends, in addition to public demand, are affecting health care costs.

- The rapid and accelerating rise in the cost of private health insurance — premiums increased 11 percent in 2001 and 8 percent in 2000 after years of relative stability in the late 1990s
- A squeeze on the current and potential resources for Medicare and Medicaid because of changing federal and state government priorities and budget deficits
- Businesses trimming or eliminating health benefits and passing more of the costs on to employees and pensioners
- More and more costs and demands for pharmaceuticals plus increases in hospital costs

TALKING POINTS

- **People are healthier than ever before. Eight out of ten elders today take care of themselves — an all-time high.**
- **Thanks to population growth, the number of elder Arizonans in poor health will increase to the detriment of the state's and personal pocketbooks. In 2000, long-term care for low-income elder and disabled residents cost the State of Arizona more than $400 million. Nationally, ill elder and disabled members of Medicare HMOs spent nearly 50 percent more of their own money for medical care in 2001 than three years before.**
- **Health care spending topped $15 billion in Arizona in 2000, and the price tags keep getting bigger. The percentage of personal health care dollars Arizonans spent on prescription drugs doubled between 1980 and 1998.**

* An establishment is a separate facility. It may be a part of a larger entity.

Health Care Totaled More Than a Trillion Dollars in the U.S. in 2000.

- **Health care expenditures totaled $1.4 trillion, 14 percent of GDP in 2000.**
- **The public sector paid for 46 percent of U.S. health expenditures in 1999, including Medicare 18 percent, Medicaid and SCHIP (care for low-income children) 16 percent and other programs 12 percent.**
- **State and local governments spent about 30 percent of the public sector dollars, an increase of 7 percent or about $153.6 billion.**
- **Private health insurance premiums grew by 7 percent, keeping pace with the 7 percent growth in benefits.**
- **Consumer out-of-pocket payments accounted for 15 percent of total health expenditures.**

Source: *Assessment of Arizona Health Care Coverage Report. The Arizona Republic.*

The U.S. ranks first in the world in health care expenditures, both as a percentage of gross domestic product (the combination of all goods and services produced) and on a per capita basis.[23] Technology drives much of the spending, and more than half of the dollars (55%) cares for as little as five percent of the population.[24] Experts expect costs to escalate as demand for improved access and quality increases along with life spans. With more time for chronic conditions to appear, calls for the latest and greatest tools and technologies to treat them are sure to increase.

Table 11: Nationally, Retirees' Spending on Health Care Increased Between 1987 and 1997.

Selected expenditures for retired households: Consumer Expenditure Survey, 1987 and 1997

Category	1987	1997
Number of persons in household	1.5	1.5
Number of vehicles	1.1	1.3
Percent homeowner	71.0%	75.5%
With mortgage	9.3%	10.1%
No mortgage	61.7%	65.4%
Household income*	$17,833	$18,206
Total expenditures**	$17,751	$19,676
Housing	33.8%	33.0%
Food	17.4%	16.5%
Transportation	14.7%	15.1%
Health care	11.8%	13.3%
Insurance	5.2%	7.4%
All other	6.6%	5.9%
Entertainment	3.3%	2.9%
Apparel	3.7%	2.9%
Other***	15.3%	14.4%

* In 1997 dollars. ** Annual average in 1997 dollars.

*** Other includes alcohol, personal care, reading, education, tobacco, cash contributions and miscellaneous.

A "household" includes people related by blood, marriage, adoption, or other legal arrangement; a single person living alone or sharing a household with others but who is financially independent; or two or more persons living together.

Source: *Consumer Spending During Retirement*, Issues in Labor Statistics, U.S. Bureau of Labor Statistics Summary 00-11 May 2000.

The total number of people in poor health almost certainly will increase due to various demographic factors.[25] At the same time, there is good news. Now more than eight out of ten elder Americans take care of themselves on their own, according to the National Academy of Sciences. "People are living more vigorously besides living longer. The rate of disability among elders has fallen under 20 percent for the first time. Improved medical care, diet, exercise and public health advances in recent decades have all contributed to a more vigorous and healthy old age. Older Americans now are better educated, take better care of themselves and are taking advantage of new medical knowledge about how to stay healthy."[26] Such declines in chronic needs and related evidence underscore the importance of education in impacting future costs.[27] Among the eldest, some studies suggest a decline in rates of heart attack and stroke and a parallel increase in cognitive impairment and dementia.[28]

Canadian research on actual versus projected health care use provides some additional perspective. One study compared actual acute hospital days per 100,000 in 1969 with projections. The 1980 projection was 1,800 days with the actual at 1,400. Likewise the 2000 projection was 1,900 and the actual was 600. Similar comparisons were made for 1978, 1985, 1993, 1995 and 1998. In each case, the actual was much less than predicted, but overall health care costs and costs for drugs ran higher than the projections. These scholars argue that the older population

is not sicker. Services are just more expensive. If we accept that the boomer will approach old age with a healthier attitude and more positive habits, the demands for health care services will in fact be less. Added to healthier behavior, pharmaceutical innovations may allow us to age in place and reduce the need for caregiving over a long period. For example, if a drug could postpone the onset of Alzheimer's disease by five years, we could reduce the need for caregiving and even institutionalization substantially. However, other experts say there are limits because the number of boomers is large, and people need more assistance as they join the "old old."

The Technology Option

Technology presents numerous options that could mitigate health care costs and the need for care. From high-tech medical tools to home appliances and clothes that monitor body functions, advocates and health care professionals see great possibilities for technology to revolutionize aging and health care. Some look to technology to reduce the number of health care workers needed, while enhancing personal independence and control. Such options may push costs down. From telemedicine to the stuffed "pet" that reminds people to take good care of themselves, new inventions are making their way to the marketplace daily. Joseph Coughlin, director of the AgeLab at the Massachusetts Institute of Technology provides an overview of how technology could change life for elders and their families.[29]

Table 12: Technology Can Improve the Quality of Life for Elders and Make Caregiving Easier.

The Vision	Benefit to Older People	Benefit to Caregivers	Example
From event to daily check up	Participatory health care with less focus on events	Informed assistance and less stress	Telephone check ups by volunteers
Single provider to networks of providers	Many products and services from many sources	Increased choices	Individual case managers
From "cold" to "caring" computers	Connectivity and entertainment	Extended independence	Robotic pet
From automobile to lifelong transportation	Safe alternative to driving	Fewer demands	Intelligent functions in cars
From "smart" to "usable" technology	Innovative devices to aid older residents	New sources of help	Computer monitored home or apartment
From assistive technology to lifelong technology	More freedom and mobility	Less physical stress	High-tech walkers
From wardrobes to wearable computing	Improve safety and quality of life	Less demand on caregiver	Cheney heart implant

Source: Joseph Coughlin, MIT AgeLab.

Continuum of Care Costs

Despite recent advances and the promise of technology, the question remains: Will there be adequate public and private resources, however deployed, to provide health care in the future aging environment? To answer this question requires an understanding of the range of demands, resources and options available along the continuum of care.

Individuals traverse a familiar pathway as they age, and the journey from independent citizens to dependent family members or nursing home residents often takes many years. Boomers will enter their mid-60s healthier than any other cohort in history thanks to advances in health technology, greater access to health care and positive lifestyle choices.[30] Unfortunately, even boomer bodies will wear out. "During the second half of the 20th century, advances in medical technology made it possible for individuals to survive for years with diseases and chronic conditions that would have meant a rapid death just a few years before. Though laudable, this created a new population of persons in need of care…and, therefore, a new population of caregivers. Many, if not most, of us will be both in our lifetimes — caregiver and the cared-for."[31]

At age sixty-five, 10 to 20 percent of a person's remaining years are likely to be spent dependent in one or more of these ways (activities of daily living such as bathing, dressing, eating and moving from bed to chair).

By age eighty-five, about half of people's remaining time is likely to require some such assistance.

Successful Aging:
The MacArthur Foundation Study.

Community Care for the Elderly Adds Up.

- **Homes for the elderly and continuing care retirement communities employ approximately 8,474 Arizonans statewide.**
- **Services for the elderly and disabled persons employ another 3,220 people.**
- **Home health care services involve 8,139 people.**
- **Nursing care facilities employ 15,574 people.**

Source: *County Business Patterns*, 1999.

Health Care is Costly for Elders, Especially if They Are in Nursing Homes.

Average Health Care Expenditures for Those Age 65 and Older, 1996

	Average Health Care Expenditure
Age: 65 to 69	$5,864
Age: 70-74	$6,744
Age: 75-79	$9,414
Age: 80-84	$11,258
Age: 85+	$16,465
Not Living in an Institution	$6,360
Institutionalized	$38,906

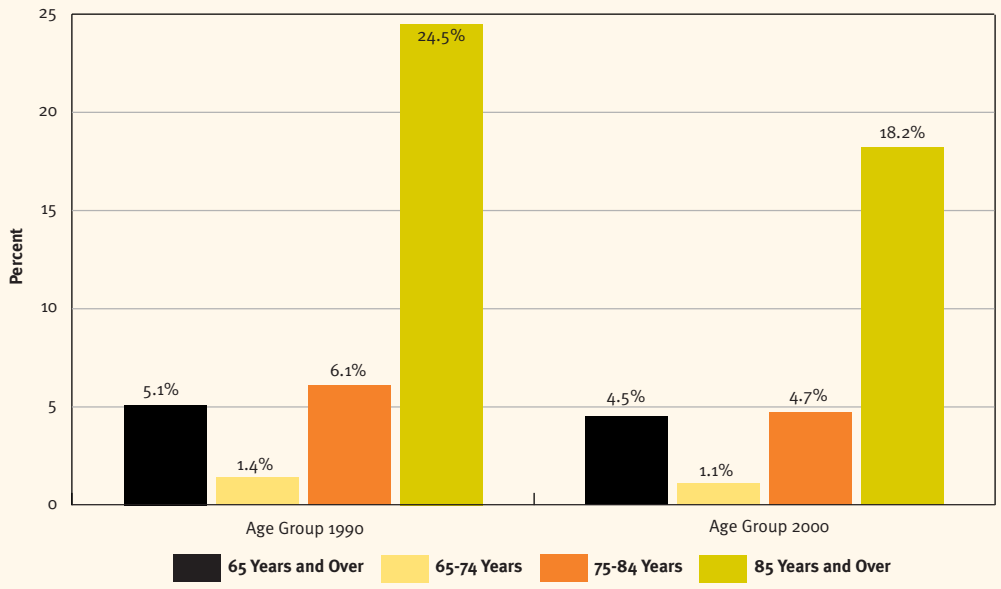
Source: Medicare Current Beneficiary Survey. *Older Americans 2000: Indicators of Well-Being.*

Experts say the demand for long-term care could double in the next thirty years.[32] Long-term care tends to be a catchall phrase now for everything from informal family assistance, home health care, adult day care, or assisted living facilities to skilled nursing home facilities.[33] Each level or service requires different types of resources. The truth of the matter is that even if just a small percentage of Arizona's next elders require long-term care (LTC), the price tag will be astounding. "The aged and/or their families pay about 40 percent of all LTC expenses out of pocket. The largest component of LTC services is for nursing homes, which represent 71 percent of LTC expenditures. The aged and their families pay, on average, 50 percent of all nursing home care costs."[34]

While most studies point out that elders prefer to remain in their homes as opposed to residing in a nursing facility, the reality is that as people go from being part of the "young old" to being part of the "old old," chronic disabilities may occur that require significantly more care. The National Long-term Care Survey examined the changes in various age groups' levels of dependence from 1984-1999. Needs increased with age in the 65–74, 75–84 and 85+ groups. However, for each of these groups, rates of dependence have fallen since the original survey in 1984.

Figure 15: Only About Five Percent of U.S. Elders (1.6 Million) Live in Nursing Homes.

Population 65 Years and Over in Nursing Homes by Age: 1990 and 2000



Source: U.S. Census Bureau, Census 2000 Special Tabulation and *The 65 Years and Over Population: 2000*, October 2001.

The Arizona Health Care Cost Containment System (AHCCCS, the state Medicaid agency) now spends about one-third of its budget on about 30,500 disabled elderly — just six percent of its population.[35]

Informal Caregiving

Assistance most often means family members provide care. The term "caregiver" refers to anyone who provides assistance to someone else who needs it to maintain an optimal level of independence. The availability of family caregivers is often the deciding factor in whether a loved one can remain at home or must move to an institutional setting. However, caregiving is a multifaceted, often

stressful, activity. It taxes many families now and certainly will be a factor in the future as the number of elders increases. Social trends of the past 30-40 years are now affecting elder caregiving, including:

- Increasing divorce and remarriage rates
- Increasing geographic mobility
- Decreasing family size
- Delayed childbearing
- More women in the workplace[36]

Some scholars have estimated that in 1990 11 people were available to provide care for each one needing it. By 2050, the ratio may be as low as four to one. As the recent University of Arizona study of aging in Pima County showed, the way in which informal care is provided is changing also. "In 1960, 40 percent of those age 65 and older lived in the home of an adult child. By 1999, this number had dropped to 4 percent."[37] ASU geographer Patricia Gober underscores that boomer elders will have "only one-half the number of children upon whom to depend for support in their old age as the current generation of elderly."[38] Those who were 65 years old in 2000 had an average of 3.65 children at 25 years of age in 1960. People who will be 65 in 2020 will have had on average 1.84 children when they were 25 in 1980. In addition, Arizona elders may have fewer families close by because of the large number of people who moved to the state to retire.[39] While a trend toward provision of care "in more diffuse family and quasi family networks" may offset this concern, the caregiving issue must be seen as a major one.[40]

The growing need for home care is among the most urgent issues of our maturing society. Contrary to popular misconception, the primary source of care...remains family and friends.

Aging in the 21st Century Consensus Report, Stanford University.

With caregiving nearly as much a fact of life as aging, understanding more about its stresses and strains is vital to thinking about capacity. Researchers estimated the total economic value of informal caregiving at about $196 billion in 1997.[41] This figure dwarfs national spending on formal home health care ($32 billion) and nursing home care ($83 billion). Another study,[42] which focused solely on informal care for older adults with chronic disabilities, projected that the costs of replacing informal help with paid home care would run from $45 billion to $94 billion annually.

Families at the Heart of Caregiving

Family members provide an estimated 71 percent of noninstitutional care.[43] According to a 1997 National Alliance for Caregiving/AARP survey, approximately one in four households are participating in some degree of informal caregiving.[44] In 1999, the MetLife Mature Market Institute estimated that more than 22 million families provide care. Caregiving is not the only activity for those who are responsible. Approximately 52 percent of informal caregivers work full time, with another 12 percent employed part time.

Nearly three quarters of informal caregivers for elders are women. The typical caregiver is a married woman in her mid-forties to mid-fifties. She works full time and spends an average of 18 hours each week on caregiving. Women on average devote 50 percent more hours to caregiving than men and average over five continuous years as a caregiver.

Source: National Alliance for Caregiving.

The caregiving role, which has been estimated as a reality for as much as 25 percent of U.S. households, comes with mental and physical consequences. For example, one-third of informal caregivers described their own health as fair or poor in a recent study. In a 1992 study, two of three informal caregivers were in ill health. In addition, one-third of these caregivers worried about juggling caregiving with other aspects of their lives, such as raising children. An estimated 20 to 40 percent of caregivers tend to children as well as one or more elder relatives.

The study pegged the economic costs to individuals at approximately $659,000 "over their lifetimes in lost wages, lost Social Security and pension contributions because they take time off, leave their jobs entirely or experience compromised opportunities for training, promotions and 'plum' assignments."

Caregiving drains $11–29 billion from U.S. businesses each year in lost productivity.

Source: MetLife Mature Market Institute.

Caregiving also carries significant costs. In 1999, the *MetLife Juggling Act Study*, done by the National Alliance for Caregiving and the Brandeis University National Center for Women and Aging, found that many caregivers gave up jobs or took extended leaves from work to care for elders. The study pegged the economic costs to individuals at approximately $659,000 "over their lifetimes in lost wages, lost Social Security and pension contributions because they take time off, leave their jobs entirely or experience compromised opportunities for training, promotions and 'plum' assignments."[45] That figure, derived from in-depth interviews with caregivers nationwide, included $566,500 in "lost wages, $67,000 in retirement contributions and $25,500 in social security benefits. Twenty-nine percent said they had passed on promotions, training opportunities and new assignments; 25 percent passed on transfers and relocation; 22 percent said they could not acquire new job skills." Providing care resulted in an average expenditure of $19,500 for food, transportation, rent or mortgage help and home health care. Considering the demand, the dollars attached to caregiving are staggering.

The U.S. Congress has taken notice of the demands placed on caregivers. Lawmakers passed the 1993 *Family and Medical Leave Act* to allow employers to support employees' responsibilities for elder care. In addition, the 2000 amendments to the *Older Americans Act* dedicated $125 million to support family caregivers. Through the National Family Caregiver Support Program, states receive funds to use with local administrations on aging and other community organizations to establish respite care systems. Respite services may take many forms, including adult day care, short stays in nursing homes or assisted living facilities, temporary home health aides or foster adult care.[46] The law provides help first to those with the greatest family or financial needs. Arizona receives nearly $2 million under the National Family Caregiver Support Program.

The Home Health Option

Because of lower costs than some other types of care and the desire of many older people to remain independent, home health care is an increasingly appealing aspect of the capacity to care for an aged population. Community-based care, provided by home health care agencies (usually for-profit businesses or private, nonprofit organizations), offers a broad spectrum of professional services that often prevent institutionalization. As revealed, though, in a recent Arizona study, home health care may be too stressed to fulfill its promise.

The discharge planners and social workers reported significant difficulty, and often delays, in placing patients with home health care after their discharge.

ASU nursing professor Carol Long recently surveyed hospital discharge planners and social workers in 31 hospitals in Arizona to understand more about community-based strategies. This study with both urban and rural respondents also assessed the state of access to home health care in Arizona. Discharge planners and social workers work with families and community resources to plan how support will be provided for those who are leaving a hospital or who have become homebound.

The discharge planners and social workers reported significant difficulty, and often delays, in placing patients with home health care after their discharge. Often patients go to alternative care settings, such as long-term care facilities, when home health care is unavailable. Some patients may be readmitted to the hospital if their care needs are not met.

Respondents expressed concern for the future, predicting the "worst is yet to come." Most respondents feared the financial implications for hospitals, when stays become longer, readmissions occur, or stopgap measures are necessary because sufficient home health care is unavailable. Others were apprehensive about inadequate reimbursements and financial restrictions and limited access to Medicare-HMO insurance in rural areas. Many discharge planners and home health care leaders worried that the "safety nets" for an aged population have been compromised because of a long list of negative events or trends such as:

- Geographic distance between family members
- Growing life expectancy and the increasing likelihood of elders living alone
- More out-of-pocket expenditures
- Complex care needs and limited options in rural areas
- Diminishing access to home health and long-term care due to limited reimbursement and other financial limitations
- Shortage of nurses and related workers

These factors tax the health care system, erode quality of life and create barriers to effective community-based health care. Those interviewed favored making home health care more available through community connections, capacity building, communication, continuum of care, care management and creativity.

With overall health care costs increasing and more elders — plus the stresses of caregiving — the economics of care become critical.

System Economics for an Aging Future

The U.S. health care model relies on a unique public-private partnership to pay for medical services. Employer-based insurance, which covers roughly 150 million American workers and their dependents (59% in Arizona), is central to the model's success. Despite the fact that almost 70 percent of the population expresses satisfaction with the employer-sponsored approach to health care, it is subjected to constant scrutiny.[41] Criticism of this model, like all health care issues, boils down to cost, quality and access. Concerns include:

- Real costs — premium increases for large and small firms exceeding cost of living increases
- Health care use — more office visits, more expensive prescription drugs and higher expectations among consumers
- Companies shifting costs to employees — premium increases passed on to employees affect low-wage workers most
- Temporary and part-time work — "nontraditional" jobs (close to 30 percent of jobs in 1997) may not have health insurance or it may not be affordable for many workers
- Coverage limitations — particularly drug benefits but including other limits and decisions resulting in cost shifting to patients[48]

These trends fuel the longstanding concern that the current American health system is operating at a suboptimal level, and that cost-access-quality conflicts are destined to escalate. In addition, Arizona holds the dubious honor of one of the highest percentages of uninsured residents in the country, although University of Arizona researchers have shown that the percentage dropped from a national high of 24 percent in 1996 to a still-higher-than-average 16 percent in 2000.[49] These patterns have led to extensive debate nationally and in Arizona about reforming the health system, particularly its payment and coverage methods, to avoid the multiple problems associated with many uninsured residents.

Unlike the working-age population, almost all seniors have some health insurance thanks to Medicare, Medicaid and Medigap policies. Currently in the United States and in Arizona, seniors comprise about 13 percent of the population, but account for about 40 percent of all health care expenditures and about 36 percent of pharmaceutical expenditures[50] because "there is more illness among the elderly and thus more opportunity to apply new technologies."[51] Because as a group they are most in need of care, elders are the major beneficiaries of the technologies that

Home Health Care May Be Unavailable Because of:

- **Regulations or restrictions of public programs**
- **Lack of registered nurses or home health aides**
- **Patient care needs beyond the skills of home health employees**
- **Reluctance among operators to care for "unsafe" patients**
- **Limited number of providers in a geographic area**

Source: *Meeting Community-Based Needs in Arizona*, 2001.

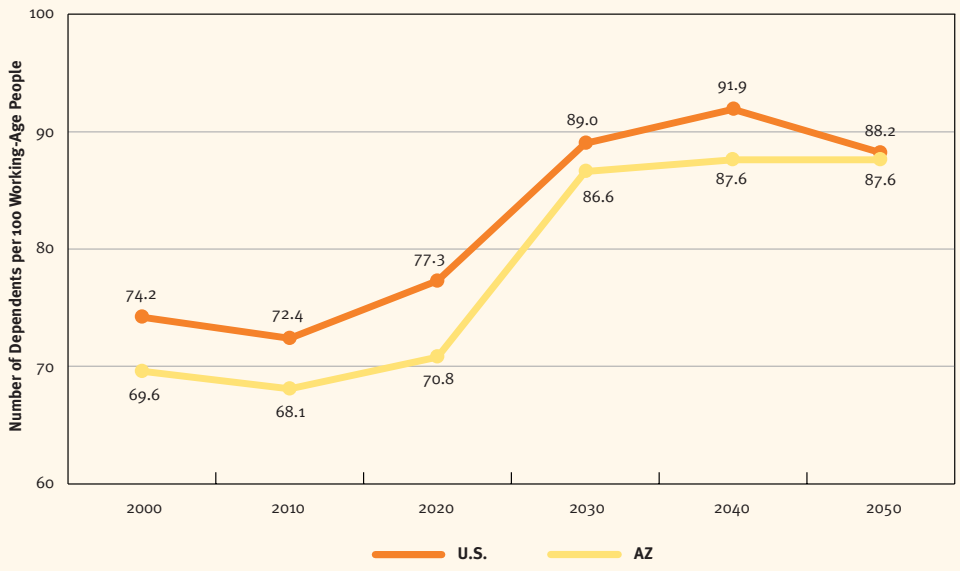
contribute to higher health care costs.[52] Yet Medicare leaves out drug benefits and does not cover long-term care costs. Seniors with the best of the "Medigap" supplementary policies may have drug benefits, but this situation leaves out less affluent seniors.

New research documents some stunning increases in the cost of medical care for elders in HMOs. Mathematica Policy Research's most recent study shows that elderly and disabled members of Medicare HMOs used nearly 50 percent more of their own money on average for medical care in 2001 than they did three years ago. The increase was even steeper for those in poor health. Out-of-pocket costs rose 62 percent, to $3,578 in 2001, for people in poor health as their share of spending increased for prescription drugs, premiums and other services not fully covered by Medicare.[53]

An aging future is certain to add major stress to health care economics as it will strain caregiving and increase demand on the health care system. In his technical paper written for The Coming of Age, University of Arizona economist Ronald Vogel demonstrates the profound effect that an older population will have on Medicare, Social Security and Medicaid. Central to his assessment is the fact that there will be more dependent persons per worker than in the past, and that expenditures for health care are expected to increase. To this Arizona expert, Social Security, Medicare and Medicaid will constitute more of an economic burden on the workers of the future, *unless* the real economy grows at a rate equal to or greater than the increase in the 65+ population — an unlikely scenario.[54] In 1960 in the U.S., 5.1 workers supported each Social Security beneficiary. In 2000, there were 3.4 workers per beneficiary, but by 2040, just 2.1 workers will be counted for each recipient. Based on Arizona data, Professor Patricia Gober illustrates how this trend will play out in Arizona.

Figure 16: Fewer Workers Will Support More Elders and Youngsters.

Dependency Ratios, 2000-2050*



*Projected. The number of youth under age 20 and elderly over 65 for every 100 people of working ages, 20–64. The increase in the numbers means there are more dependents and fewer workers.

Source: Calculated from U.S. Census Bureau National Population Projections. Arizona Department of Economic Security Population Projections.

Reconciling Costs and Resources for Care in an Aging Future

Important as Medicare is to health care capacity, it is not the only piece. While difficult to estimate with precision, we know that families, volunteers and community groups, including faith-based organizations, invest substantially in care that is invaluable in postponing or avoiding more expensive options. Surveys show that about 70 percent of Americans are concerned about paying for long-term nursing care, but only 6-13 percent of Americans (depending on the source and product) own such insurance policies. In Arizona at the end of 2001, long-term care policies covered only about 75,000 people, according to the Arizona Department of Insurance.

Meanwhile, the phrase "better living through chemistry" has never been more accurate or appealing. Drugs are transforming the quality and length of life while substituting for institutional remedies. Unfortunately, drugs also can be costly.

During the 1990s, prescription drug expenditures increased at a much more rapid rate than all other health care expenditures. Drug price increases accounted for 19 percent of the expenditure increase between 1993–1997 and 24 percent between 1997–2000. In both periods, utilization (the number of prescriptions dispensed) contributed the most to drug expenditure increases. Indeed between 1992–2000, the number of drug prescriptions dispensed grew from 1,873.4 million to 2,979.9 million, or, from 7.3 prescriptions per capita to 10.8 per capita. Seniors spend roughly four times more on prescription drugs than younger people. In addition, a flood of safer, more effective drugs have come to market in recent years, although they are also more expensive to research and produce than many older drugs. That is why "Types" in the last row of Table 13 accounted for 33 percent of the increase in drug expenditures between 1993–1997 and 28 percent between 1997–2000.[55]

Table 13: Use Skyrocketed and Companies Introduced New Drugs in the 1990s.

Relative Contribution of Price, Utilization and Types of Prescription Drugs Consumed to Rising Prescription Drug Expenditures, 1993–1997 versus 1997–2000

	% 1993–1997	Average Annual % Changes	% 1997–2000	Average Annual % Changes
Price*	19	1.9	24	3.8
Utilization**	48	4.6	48	7.1
Types***	33	3.2	28	4.2

* Manufacturer price increases. ** Number of prescriptions dispensed. *** Types of prescription drugs consumed.

Source: *The Reasons Behind Rapidly Increasing Pharmaceutical Expenditures,* 2002.

The increasing importance of prescription drugs as a component of personal health care expenditures is generally attributable to three factors: 1) growth in insurance coverage for prescription drugs; 2) rapid introduction of new, more effective drugs; and 3) explosive growth of direct-to-consumer advertising. In 1990, out-of-pocket expenditures paid for 59.1 percent of prescription drugs; by 2000, this percentage had fallen to 34.3 percent. Just 22 new drugs came into use in 1994, compared to 53 new drugs in 1996.

Arizona's experience with prescription drugs generally mirrors that in the United States. Until 1992, Arizonans devoted a smaller percentage of personal health care expenditures to prescription drugs than did the United States as a whole. By 1998, though, Arizona had caught up, spending 9.5 percent of personal health care expenditures on drugs to the nation's 8.9 percent.

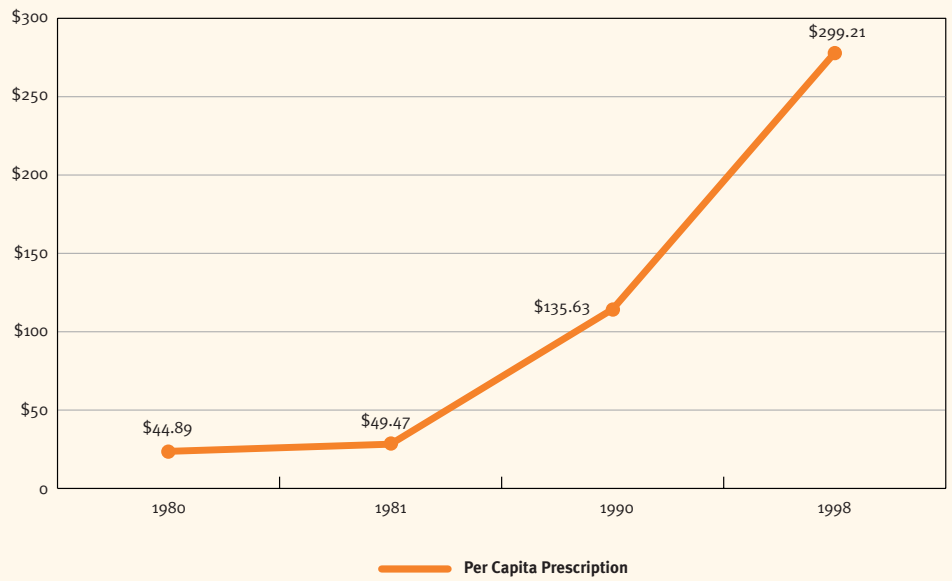
By 1998, though, Arizona had caught up, spending 9.5 percent of personal health care expenditures on drugs to the nation's 8.9 percent.

Prescription drugs as a percent of personal health care expenditures nearly doubled in Arizona between 1980 and 1998. In 1980, prescription drugs accounted for 5 percent and in 1998 9.5 percent.

The Reasons Behind Rapidly Increasing Pharmaceutical Expenditures, 2002.

Figure 17: By 1998, Prescription Drugs Absorbed About $300 Per Person in Arizona.

Arizona Per Capita Prescription Drug Expenditures, 1980–1998



Source: *The Reasons Behind Rapidly Increasing Pharmaceutical Expenditures*, 2002.

Some observers see the increase in the availability and effectiveness of new drugs and spending on them as a problem. However, the issue is not that these drugs are ineffective; indeed, strong evidence suggests that, relative to other developed countries, the United States spends too little per capita on prescription drugs with respect to health outcomes. Affordability, and consequently access to these pharmaceuticals, is the fundamental issue. About 39 million Americans participate in Medicare and, for the most part, the program does not cover outpatient prescription drugs. Nearly 12 million Medicare enrollees purchase so-called Medigap policies, but only three of the ten offer even minimal drug coverage.

Inability to pay by some persons, particularly seniors, might not even be a problem, if the majority of citizens did not rightly view access to health care and prescription drugs as a right. An effort was made to resolve the outpatient prescription-drug problem for seniors in 1988 with the *Medicare Catastrophic Coverage Act (MCCA)*. The MCCA was quickly repealed though because of its unpopular (albeit misunderstood) financing provisions. Ever since the demise of the MCCA, Congress has been reluctant to deal with pharmaceuticals through Medicare. Many states have begun to address the income issue with help for low-income elders and others.

Overall health care cost increases and drug and bio-technological cost increases return us to the tradeoff dilemma of American health care that can only be reinforced in Arizona. Scientific breakthroughs vastly improve the quality of health care, and, in the long run, they may decrease health costs and increase capacity. But, what will happen to those who cannot afford the wonder drugs? Countless Arizona anecdotes detail seniors' decisions about drug purchases versus groceries and bus trips to Mexico to find affordable drugs and so forth. Affordability, as economist Vogel says, is certainly Arizona's issue.

Both major political parties are trying to find ways to extend drug benefits to seniors without such coverage. Meanwhile, programs from drug companies may reduce out-of-pocket prescription

costs for low-income elders. Pfizer Inc. announced its "Share Card" program in January 2002. The program helps poor elders by charging $15 per month for many drugs instead of the average retail price of $65. Pfizer chairman Henry A. McKinnell said the company's program seeks to "bridge the gap in drug coverage until broader Medicare reform" is adopted. An estimated 7 million people could qualify for the program.[56]

Major Arizona Programs for Elder Health Care

Arizona obligates millions of state dollars to its share of two major Medicaid programs with direct benefits for eligible elders: AHCCCS and Arizona Long-Term Care System (ALTCS). In 1982 Arizona enacted its Medicaid program to provide health care for those who could not afford it. In 1988, the Arizona Legislature decided to include long-term care benefits for AHCCCS beneficiaries. Arizona's program has three unusual features:

- Beneficiaries must receive long-term care services through managed care organizations. Arizona is the only state in the United States with such a requirement.
- ALTCS created a separate managed care system for elders to provide a full range of medical services.
- County governments must pay ALTCS costs not paid by the federal government.

Approximately 110,000 non-institutionalized Arizonans age 65 or older need some type of assistance with mobility or self-care.

Arizona's Community Based Services and Settings Report.

As of October 2001, ALTCS counted 32,720 enrollees: 12,570 developmentally disabled (DD) and 20,150 elderly and physically disabled (EPD). By 1999 the EPD population made up 67 percent of the ALTCS population and of that, 43 percent were in residential settings that provide an alternative to tradition nursing home care or in their community receiving in-home care services. As a result, although nursing home enrollments have increased over the last four years, as a percentage of the total population there has been a decrease of four percent. ALTCS uses a network of program contractors throughout the state for service delivery to the EPD population. The Native American population served by ALTCS that lives on a reservation has their cases managed by either their tribe or through the Native American Community Health Center.

The ALTCS budget is approximately 30 percent of the total AHCCCS budget for 4 percent of the population.

Arizona's Community Based Services and Settings Report.

ALTCS funding comes from federal Medicaid funds (65%), state funds (14%) and county funds (21%). For federal FY 1999, ALTCS funding totaled $764,135,800 compared to a total state budget approaching $7 billion. The EPD portion, approximately $560 million, represents 30 percent of the total AHCCCS budget, while the ALTCS EPD population is about 4 percent of the total AHCCCS population.[57]

A Step Toward More Community Assistance

In addition, Arizona has started to see the value of alternatives to nursing home care. The Arizona Department of Economic Security (DES) Aging and Adult Administration oversees the Non-Medical Home and Community Based Services programs. Services include: adult day health care, home health aid, limited home nursing, housekeeping assistance, home delivered meals, personal care and respite care. This program is designed to meet the needs of the aged and disabled population that is no longer able to perform all of the necessary daily functions to remain independent, but is not yet in need of some form of institutionalized care. It is an opportunity for Arizona to provide a cost-effective solution for those needing basic assistance. "Anecdotally, the NMHCBS program may keep consumers from entering into the ALTCS program by quickly providing services that help them maximize their independence at an earlier stage in the need for assistance."[58] However, the majority of funding is provided by the state (74%), and, therefore, continued appropriations are subject to other priorities.

In 1999, when the state's economy was robust, more than 1,100 people stayed on a waiting list for community-based services because the funding was insufficient to cover the demand.

Arizona's Community Based Services and Settings Report.

Proposition 204

In November 2001, the voters of Arizona passed Proposition 204, Healthy Arizona II to increase the numbers eligible for coverage under AHCCCS. The ALTCS population and bundle of services are not affected directly; but some eligibility criteria have changed.

The overall state budget share for aging health efforts has expanded with significant matching funds from Medicaid and an important nudge from Arizona voters. These are major components of the state's response to elder health care needs. Based on what Arizonans said in *The Coming of Age* research serving low-income residents is something Arizona and the nation should do.

But as has been shown repeatedly in this section, in health care things often are easier said than done.

People to Care for an Older Arizona

Regardless of what happens to health care, capacity eventually comes down to people — those who care for elders, whether through health-related occupations, research and development or community agencies or through personal relationships. While family caregivers are most numerous, nearly 200,000 Arizonans work in health and related occupations. The federal Occupational Employment Statistics program (a major forecasting program in the U.S. Bureau of Labor Statistics) includes 48 health occupations ranging from medical and health services managers to all types of technicians, assistants, nurses and physicians. In addition, numerous types of scientists and academicians are engaged in research with a connection to health.

Some aspects of health and related research are viewed as sources of quality jobs for the future as well. Public institutions and private sector businesses involved in Arizona's Bioindustry "Cluster"* and the Senior Industries "Cluster" are working to build businesses that will increase high-wage employment in Arizona. Recent efforts to organize public and private resources to recruit the International Genomics Consortium to Arizona reflect the interest in the economic and social value of health and related fields.

The most immediate concern, however, is the precarious supply of workers for the most traditional health care fields: physicians, nurses and those who assist them. Where will the hands and minds come from to provide health services as more elders require care? While a shortage of nurses has grabbed the biggest headlines, concerns for the health care labor force extend far beyond one occupation.

A Shallow Pool of Physicians

Arizona has approximately 11,480 practicing physicians (who work outside of federal programs) or 240 physicians per 100,000 in population — less than the national average of 285 per 100,000.[59] In 2000, the state counted just 99 medical school graduates. (The good news is that they reflected the state's ethnic and racial composition.)

With the state's comparatively low number of physicians and high rates of growth, the possibility of a shortage of physicians nationally is not good news. According to the American Medical Association, in 1998, medical school applications slipped for the third year in a row to 41,004 from a record 46,968 in 1996. In Arizona, interest dropped from 1,149 applications in 1998 to 1,076 in 1999.

In addition, some specialists are less plentiful than they should be with more aged residents in the near future. For example, the United States and Arizona lack geriatric-trained physicians. Of the 670,000 MDs working in the United States today, only 8,000 are certified in geriatric medicine. The U.S. Bureau of Labor Statistics anticipates a need for more than 20,000 geriatric specialists by 2020.[60] A major reason for the shortfall is that geriatrics traditionally has not been as attractive as other fields. Treating older adults for health problems that cannot be cured reportedly is less appealing than other types of medicine.

TALKING POINTS

- **In 1960, 5.1 workers supported each Social Security recipient. In 2000, there were just 3.4. By 2040, 2.1 workers will be counted for each Social Security beneficiary.**
- **Health care workers are in short supply. Arizona has fewer physicians and registered nurses than the national average.**
- **Family members provide approximately 70 percent of noninstitutional elder care. On average, caregivers may sacrifice as much as $600,000 in income and opportunity to care for elders.**

Health-Connected Industry Clusters in Arizona

"Senior Industries" and "Bioindustry" are two of Arizona's economic "clusters." These areas help to drive the Arizona economy and are comprised of:

- **Medical, financial, legal, real estate and accounting services for retirees.**
- **Life science activities, excluding health care delivery, such as medical devices, pharmaceuticals, research and testing.**

Source: Arizona Department of Commerce.

* As defined by the Governor's Strategic Partnership for Economic Development, a cluster is a geographic concentration of interdependent competitive firms in related industries that do business with each other. Each cluster includes companies that sell inside and outside of the region and support firms that supply raw materials, components, and business services.

Most physicians (87%) say the overall morale among doctors has decreased in the last five years, according to a new survey.

Source: Kaiser Family Foundation, 2002.

In 1999, the American College of Cardiology estimated that the need for cardiologists would rise 66 percent by 2030 and 93 percent by 2050. On the other hand, without intervention, the number of cardiologists would grow by only one percent each year.[61] The *Journal of the American Medical Association* warned last year that internists, pulmonologists and cardiologists soon will be in short supply also.[62]

This issue should not come as a total surprise. The projected dearth stems, in part, from the fact that many physicians are themselves aging baby boomers. In addition, as almost any doctor will tell you, the medical profession has changed dramatically in the past 20 years. As a result, the work of physicians has been transformed.[63] Changing perspectives on work and leisure and less residency time are some of the changes experts say have contributed to a smaller "supply" of physicians just when these leaders of the medical workforce are aging.

Making It with Fewer Doctors

With the possibility of fewer physicians, new sources of workers and different ways of providing services have to be considered. In the 1960s, a predicted physician shortage resulted in a push for more doctor education programs and an increase in the number of medical schools. Now the trend is "substitution," or utilizing nonphysician clinicians, such as nurse practitioners and physician assistants, to a greater degree. Nonphysician clinicians can play considerable roles in care in part because "advanced practice" nurses (those with specialized training beyond a bachelors degree) and physician assistants enjoy greater latitude in how their time is allocated among patients and other duties. The number of nurse practitioners nationally increased 200 percent in the 1990s with a 97 percent increase among physician assistants during the same period.[64] Approximately 660 physician assistants practice in Arizona. At this level, Arizona counts just one physician assistant for every 10,000 population compared to two per 10,000 in the United States.[65]

Small-town residents often assume trips to Phoenix or Tucson for medical care.

Even if more people could be recruited for medical training, graduates may not set up shop in the areas with the greatest scarcity of doctors.[66] Although 20 percent of Americans (and about 20 percent of Arizonans) live in rural areas, less than 11 percent of the nation's physicians practice in those areas, and the number of doctors choosing to begin their practices in metropolitan areas outpaces that in rural places. Rural physicians do tend to work longer hours and have more patient visits per week than their metro counterparts, according to *Rural Health News*. Rural-area doctors average 16 percent more time with patients and have 38 percent more patients. In rural communities throughout the United States, on average, one primary care physician serves a population of 3,500 when the recommended ratio is one per 2,000. One ray of hope comes from a University of Pennsylvania study. The research showed that medical students who come from rural areas were more likely to choose to practice in a rural environment.

If you have specialized requirements, you're going to be out of here.

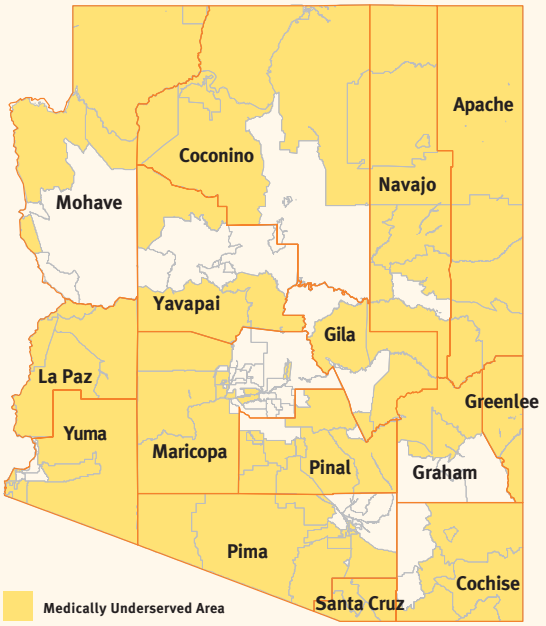
Kingman Focus Group Member.

Arizona also struggles with fewer physicians and specialists in smaller areas, although substantial population growth in such areas as Cottonwood, Prescott, Flagstaff and Yuma has made smaller areas more attractive and increased the range of medical services available locally. Hospitals and medical centers in Prescott, Flagstaff and Safford are only some of the facilities that are expanding to meet increased demands. Prescott Valley's first full-service hospital, an extension of the Yavapai Regional Medical Center, is opening. Even so, the Arizona Department of Health Services categorizes much of the state as underserved to prompt allocation of specific federal funds to these areas. On the other hand, the most attractive of Arizona's smaller communities for retirees are within driving distance of metro Phoenix and Tucson. A number of interviewees for *Gray Matters: Senior Industries in Yavapai County*[67] confirmed that, while medical care is vital to the various communities' well being, residents assume trips to metro Phoenix for serious care.

Figure 18: The Future for Arizona Elders Would be Brighter if Most of the State Were Not "Medically Underserved."

The Arizona Department of Health Services designates "medically underserved" areas, including those without sufficient health professionals (according to federal guidelines) primary care facilities, or related services. Native American reservations, which struggle the most with inadequate health services, account for a substantial portion of the "underserved" area.

Source: Office of Health Systems Development, Arizona Department of Health Services, 2001.



Not Enough Nurses Now

Few would dispute a shortage of nurses in Arizona and across the country. Nationally, an estimated 500,000 registered nurses have left the field, and fewer young people are choosing nursing as a career. In 2000, the federal General Accounting Office listed Arizona as one of the highest shortage states. In a survey of Arizona hospitals in August 2001 by the Arizona Hospital and Healthcare Association (AzHHA), 91 percent of respondents said their facilities had "more jobs than people" for registered nurses. The lack of nurses and other types of personnel had curtailed services and increased waits. Seventy-three percent reported exceeding standard occupancy levels, and 82 percent had diverted people from emergency departments. Nearly two-thirds of respondents had seen waits for surgery increase.[68] AzHHA also reports a statewide average registered nurse vacancy rate of 16 percent. That level of rate suggests that more than 5,000 RN jobs are unfilled.[69] A mid-2001 labor force survey of approximately 3,000 employers in Phoenix further highlighted the need for nurses and related workers. Among the 20 occupations with the "most relative openings," four nursing or related occupations ranked highly. And things will not get better soon. Medical professionals project that the supply of nurses will be at least 20 percent below what is needed by 2020.[70]

Table 14: Nursing and Related Positions are Plentiful in Phoenix.

Medical Occupations in the Top 20 Jobs by the Number of Openings, Summer 2001

Occupation	Rank	Average Experienced Wage
Medical records technician	3	$9.97
Medical assistant	6	$11.10
Nursing aides, orderlies and attendants	10	$9.65
Registered nurses	13	$20.65

Source: ERISS Phoenix Labor Market Survey, August 2001.

It is considered both a supply and a demand shortage: steep population growth...a diminishing pipeline of new students to nursing, an aging workforce and a baby boom bubble that will require intense health care services. These issues are occurring just as the majority of nurses are retiring and job opportunities within health care are expanding.

Facts About the Nursing Shortage, Sigma Theta Tau International.

More than 90 percent of Arizona's nurses now work in the nursing field (a larger share than the national average), and 60 percent serve in hospital settings.[71] But only seven percent of Arizona nurses hold master's or doctoral degrees, so the pool of nurses trained at the highest levels is small. Even fewer nurses, 1,269 or 4 percent, qualify as advanced practice nurses.[72]

This is not the first problem period for nurses. Especially after World War II, new hospitals, nurses leaving for family life and fewer nursing schools created a tight market for nurses that periodically has gotten better and worse. To address the needs after the war, the licensed practical nurse and nursing assistant occupations were created. In 1964, with the impetus of Medicare, Medicaid and other federal supports for health care, the *Nurse Training Act* sought to increase the supply of nurses nationwide. Similar legislation followed in 1971. In the 1980s, the issue was more a mismatch between places of work and places of need, rather than too few nurses. By the 1990s though, the issue was numbers of nurses, as well as specialties and places of work.

In particular, difficulties with both recruitment and retention have combined to demand attention. Growth in places and types of work in recent years has allowed nurses more employment and career choices inside and outside of hospitals. Mixed messages about health care's future also may have affected the profession. For example, managed care's message was that hospitalizations would be shorter and the security of a nursing career might be low. A perception of HMOs as allowing too little time for services and too many patients also reduced nursing's appeal.

Arizona experts and nurses themselves often cite negative working conditions, especially stress and understaffing, as a major source of frustration. In Arizona research, nurses noted frustration with too little time with patients and too many patients. Increased compensation would be one strategy for change, according to many experts, but surprisingly in this state pay raises ranked lower on a list of priorities than did better working conditions.[73]

Additional contributing factors to the nursing shortage include declining enrollments at nursing programs and the aging of the nurse workforce and nursing faculty. One-third of the current nurse workforce nationally is over 50 years of age.[74] In Arizona, according to the Arizona Nurses Association, 42 percent of the state's nurses have celebrated more than their 50th birthday. For older nurses, returning to eight-hour workdays instead of the prevalent twelve-hour shifts, in addition to greater flexibility on work schedules, might induce them to forego retirement or a new work setting for a time.[75]

Arizona is working to identify solutions to the nursing workforce shortage. The state is one of over 20 sites selected nationally by the Robert Wood Johnson Foundation for involvement in a five-year study project. The Arizona Hospital and Healthcare Association has initiated a number of workforce efforts. Governor Jane Dee Hull has created a task force to recommend how to fill the nursing ranks. Tucson Electric Power has pledged $150,000 for nursing scholarships at Pima Community College. Banner Health System also announced an initiative to begin attracting high school students to health jobs. Arizona State University is slated to receive $244,000 in federal funds for Advanced Education Nursing Grants and more in Basic Nurse Education and Practice Grants. Change cannot come soon enough. AzHHA's workforce expert Anne McNamara notes, "Given the aging of the population, fundamental changes will be needed to ensure we have enough caregivers to meet the growing demand for health care services."[76]

Workers Critical to the System

Paraprofessional workers who are most closely associated with the long-term care industry, namely nursing assistants, home health aides and personal assistants, are in the midst of a national and state shortage as well. The U.S. Bureau of Labor Statistics estimates personal and home care assistance employment as the fourth-fastest growing occupation by 2006.[77] The Urban Institute's recent study, *Who Will Care for Us? Addressing the Long-term Care Workforce Crisis*, points dramatically to the need for new solutions. In Arizona a 10 percent vacancy rate in nursing homes for certified nurse assistants underscores the Urban Institute's findings.[78]

These jobs are tough to fill for some good reasons. Chief among them are negative perceptions of the occupations and low pay. Nursing assistant positions often are viewed as unskilled jobs involving potentially unpleasant duties and hard physical work. In a study completed in 2001, the Arizona Association of Homes and Housing for the Aging and the Arizona Hospital and HealthCare Association showed the median wage for nursing assistants in hospitals with over 100 beds as $9.34 per hour.

With turnover rates in nursing homes ranging from 45 to 105 percent nationally with similar levels in Arizona, recruiting, training and retaining paraprofessional health care workers are vital to preparing for the coming of age. As has been the case in the past, the stronger the economy, the higher the vacancy rates are for nursing assistants. However, today's shortage is predicted to be so significant as the population ages that even the current economic downturn will not bring in sufficient workers. Welfare-to-work individuals theoretically provide a new pool of potential workers, but the low pay — and the dead-end image — have hampered training efforts. On the other hand, nursing positions offer a clear career ladder that could work for workers and employers, given strong incentives and support.

Numerous Arizona institutions are trying to address the workforce needs. For example, the Center on Aging, sponsored by the College of Nursing and the College of Public Health at the University of Arizona, has a strong track record in education and training in addition to research. However, Arizona lacks a formal geriatric advanced training program for nurses and a Department of Gerontology at any state university. Instead, the University of Arizona's medical school program and nursing program include geriatrics in Family Practice instruction.

Another option for filling shortages could be immigration of nurses from other nations. In 2001, the Arizona Hospital and Healthcare Association recommended to Arizona lawmakers that immigration laws be made more flexible "to allow qualified health care workers to enter the nation more quickly [and to] modify the H-1B visa program to include RNs, and reinstate the H-1A visa program." The *Nurse Reinvestment Act* and the *Nursing Education and Employment Development Act* have been introduced in Congress. Both would provide scholarships and loan repayment incentives in exchange for commitments to work in areas of severe nurse shortages.

Growing the Pool of Workers

In recent decades, Arizona has depended on migration for large numbers of skilled, educated workers, but the state also has developed its capacity to address workforce issues. Because of the wide range of health care occupations, many types of public and private entities play — or could play — a part in filling workforce needs. One effort that holds great promise is the Governor's Council on Workforce Policy, a 25-member governor-appointed body that is now charged with overseeing workforce development in Arizona.

There will always be some people who can't wait to have a life of leisure and who will never want to work again in any capacity. Others will want to work on a farm, teach at a college, or do something else that's meaningful to them. Retirement will become known for what it already is to so many: a new phase of life.

American Demographics, November 2000.

In a 2001 executive order, Governor Jane Dee Hull charged the Governor's Council on Workforce Policy with developing a system capable of responding to the diverse social and economic trends now affecting the state. This policy making body, along with local Workforce Investment Boards, has taken on many substantial tasks that go far beyond meeting the requirements of federal job training programs. Particularly at the state level, the Governor's Council for the first time coordinates the planning and delivery of workforce development services among K–12 education, higher education, community-based organizations and all other employment, training and welfare agencies. In short, everyone who claims a piece of the workforce pie sits around the same table and grapples with the same issues.

In its work, the Council acknowledges that an entire community (or the entire state), not just schools or employment programs, shares responsibility for the quality of the workforce. This broad-based approach, though, hinges on the efficient utilization of all federal, state and local resources and appropriate matches between workforce goals and activities and those of economic development. The federal *Workforce Investment Act* and other statutes provide the opportunity to consolidate the planning, policy and oversight functions of federally funded programs. These powers in the hands of business-led policy making boards present significant possibilities and reasons for optimism about Arizona's workers and the state's prosperity.

Current workforce efforts should help to address Arizona's health capacity, but success depends on many factors. Keeping today's boomers in the workforce is another positive strategy.

Boomers: Too Valuable to Let Go

Morrison Institute for Public Policy detailed the serious trends behind boomers in the workplace in *Five Shoes Waiting to Drop on Arizona's Future*: 1) In-state boomers' aging and retirement could create shortages of skilled workers in health and nearly all other fields; and 2) The changing tastes of out-of-state "empty nesters" and high-end retirees could leave Arizona out of the game of attracting them.[79]

Indeed, survey after survey underscores an aging workforce's new thoughts about work. In its annual survey of boomers, and now of "leading-edge" boomer retirees, the Del Webb Corp. showed that newly retired boomers are looking fondly back at work. Almost half of the respondents (age 38-55) said they are considering starting a business or pursuing another career. Work holds attractions of activity, money and social connections. This change may be part of the boomer "seeker" mentality that is always looking for a new experience. On the other hand, many boomers have been forced out of jobs by downsizing or regret choosing early retirement. Whatever the reasons, the next generation of elders is likely to:

- Remain in the workforce longer, especially if the flexibility of jobs increases
- Try out a new career or business after retirement
- Consider community service to be their new "job"
- Go back to school

Redefining "Active" as Some Type of Work

In Arizona today, 13 percent of the state's labor force (about 76,000 people) is 65 or more years of age. Thanks to federal legislation during the Clinton administration that allows those over 65 greater latitude to work without affecting Social Security benefits, employment is now more attractive to elders. The rewards to the individual and Arizona would be tremendous if the

boomers remain in the workforce. Support ratios would be improved with boomers continuing to contribute payroll taxes. Workers also could claim health benefits from their employer thus delaying the use of Medicare or at least utilizing Medicare to a lesser extent.

Today's elder workers include those who need to earn to meet their basic expenses, as well as those who tired of their "early retirement" or who work to remain active. Many who have left a career often return to work as consultants, employees or business owners in the same or related fields. Stories abound of housing developments in "senior" communities in Arizona and elsewhere where home offices and computer connections now rank as critical parts of a housing package.

Advocates have touted the value of older workers for many years. The reality for elders, though, in a still youth-oriented culture often has been negative. To improve the work experience for this and the next group of elders, human resource experts say employers need to look at their attitudes towards older workers and consider more flexible hours, phased retirement, retraining or other strategies to make the older worker comfortable and willing to stay.

The Coming of Age survey respondents reflect the spectrum of opinions about work. Just over 40 percent (42%) of those interviewed indicated a plan to retire before becoming eligible for full Social Security benefits, and a like number (46%) said they planned to work past the age of full Social Security benefits. The most prevalent reason for working is a desire to be employed, but income and benefits count too. Of those who said that they would continue working past the age of full Social Security benefits, more than half (53%) said that continuation of health insurance was a very important factor in their decision (another 28% said that it was a somewhat important factor). Despite the mention of income and benefits, more than 70 percent of respondents described themselves as confident that they would have enough income when they retired. However, those who were "somewhat" confident outnumbered the "very confident" by two to one. On the other hand, many respondents look forward to not working during retirement and having more choices about what to do with their time. One person said they anticipated retirement for "freedom and time off...leisure time...not being tied to a job."

New Opportunities for Businesses in Health and Other Fields

Tomorrow's elders may be the next pool of entrepreneurs, considering the dramatic current growth in women and minority-owned businesses and the high levels of labor force participation among baby boomers. One Arizona health expert noted how the complexity of health care and health insurance today already has created opportunities for businesses to monitor care and billings or to function as "brokers" for various types of care. As one Phoenix focus group participant said, "If there is a demand, there'll be a supply."

Unpaid Should Not be Unvalued

One estimate of volunteer activity among Americans 65 and over showed that the number who volunteer increased from about 11 percent in 1989 to 15 percent in 1999.[80] Half of 50 to 75 year olds in a recent survey "rank volunteering or community service as the most important part of their retirement plans, second only to travel."[81] In Arizona, those 55 and over do nonpolitical volunteer work at about the national average.[82]

One of the areas in which experts say volunteers should be more valued is caregiving. Caring for children, aged relatives or countless other activities go unrecognized and unappreciated in a world that defines "productive" as wage earning. Advocates have suggested moving to "social accounting" to include the value of unpaid caregiving in measures of the nation's total output.

I really don't expect to live long enough to retire. I expect to work until I die.

The Coming of Age Survey.

I want to work until I can't.

The Coming of Age Survey.

Implications of Continuing Education for Elders

Arizona State University, Prescott College and the state's community colleges all have recognized the potential of elder residents as students. Whether wanting to change careers, finish a postponed degree, or simply pursue an interest, thousands of Arizona's postsecondary students are older than the traditional college age. In addition, some institutions, notably the University of Arizona, have combined senior living with educational opportunities. The Museum of Northern Arizona sponsors a housing community for elder residents where residents may benefit from educational and volunteer opportunities at the museum and at the museum-associated charter high school, Flagstaff Arts & Leadership Academy. These initiatives are just some of those in Arizona that offer opportunities for elders to play greater and more varied roles in community life, while making the goal of lifelong learning a reality.

Professionals Worry Today, Wonder About Tomorrow

Workforce Worries Among Professionals

When advocates and professionals look at today's workforce issues in health care and caregiving, they worry. Recruitment, retention — any workforce issue — leads to a spirited discussion of many problems such as low pay, stressful conditions and inadequate skill levels. Some also express frustration with what they see as a lack of interest from workforce programs and educational institutions in caregiving jobs and training opportunities. During discussions with private, non-profit and public stakeholders, every workforce issue suggested in national studies surfaced as an issue in Arizona. Baby boomers changing careers and roles may be good news for the stressed health care industry if the right combination can be found to appeal. Whether through paid work, unpaid service or education, tomorrow's elders likely will seek out new opportunities for productive, even profitable, lifestyles.

Healthy Aging for People and Communities

It would be easy to develop a pessimistic view of the future of aging and health considering the data on the cost and consequences of ill health, and by implication, aging. But research also indicates that disease and disability are not inevitable consequences of getting older. "Old age itself is not associated with increased medical spending. Rather, it is the disability and poor health associated with old age that are expensive."[83] Using preventive services, eliminating risk factors and adopting healthy lifestyles can, and do, improve how people age.[84] Lifelong learning, nutrition, exercise and preventive health care contribute to quality of life and health.[85] The "new gerontology" outlooks prevalent now do not diminish the potential severity of the challenges of age. Instead, they offer options for individuals, community leaders and policy makers that could have a profound effect on the future.

The healthy aging perspective deserves reinforcement for two major reasons. First, baby boomers already enjoy better health than earlier generations, and many already report acting to safeguard their health. Second, healthy aging offers the opportunity to create the brightest future for elders and for Arizona. If individuals make smart choices and communities support them, tremendous personal and public costs may be avoided. In addition, evidence is growing that people who are "unusually healthy for their age, sex, race and level of education tend to move from locales with poor health outcomes (high death rates, high incidence of heart disease, high levels of disability, etc.) to those with good health outcomes, and conversely unhealthy people move from healthy to unhealthy places."[86] Health status, thus, has a very real impact on communities since healthy places will tend to attract healthy people, and healthy people boost the quality of life in a community.[87]

Arizonans Seem to "Get It"

Many of the Arizonans who participated in The Coming of Age research appear to have gotten the healthy aging message. A sizable number of respondents reported "taking good care" of themselves. Those who were most optimistic about the future mentioned strong family connections and high levels of activity. The great majority of respondents (71%) believed their health is better than their parents at the same age. Nearly the same number rated their health as either excellent or very good.

Based on these responses, many Arizonans seem to be role models for healthy aging. Remaining healthy, though, is not a given among those in the research. Health can deteriorate quickly and unpredictably. A below-the-surface uncertainty may color outlooks and expose the need to do more to promote the maintenance of health. In addition, it is easy to overstate the extent of one's positive actions. Respondents may not be doing as much as they say nor be as sure about their healthy futures as they sound.

Current health problems, fewer resources or other demands may put healthy aging on the "back burner" for many Arizonans. The survey participants with the lowest incomes and greatest health problems were the most pessimistic about the future. Arizonans' feelings seem to be in tune with their peers nationally. A recent nationwide survey of adults similar to the Arizona survey showed that most adults anticipate keeping up their lifestyle in retirement, and they feel that they have enough saved to do so. However, nearly two-thirds worried about a sudden illness or disability and admitted their savings would not cover long-term care costs.[88]

TALKING POINTS

- **Aging does not have to be a disaster. Florida and other states and cities offer models for making communities "elder ready" and thus better for all ages.**
- **Elder-friendly places treat older adults as resources and offer the housing, culture, safety, volunteer options, and health care that make sense. The communities boomers want feature culture, jobs and amenities, whether they have lived there for a month or a lifetime.**
- **Easy mobility for elders is key to better health and quality of life. Arizona's love affair with the auto will have to end to allow for more options.**

I take good care of myself now. I eat right and exercise. I do not smoke. I think if I continue to take care of myself it will pay off in the future. I also have a strong religious belief which will carry me well into the future.

The Coming of Age Survey.

Florida's Services to Elders program includes:

- Home and Community Services Programs
- Nursing Home Preadmission Screening
- Self-care and Community Volunteer Initiatives
- Long-term Care Community Diversion Pilot Program

Examples of Smart Policy

Public policy that promotes healthy aging is smart policy, as is policy that affirms communities as places that support health and growing older in positive ways. Robert McNulty, President of Livable Communities, said in reference to the nation's obesity epidemic, "This challenge needs civic engines, not just the health side."[89] The same is true for aging. Increasingly advocates and policy makers are considering what constitutes "elder friendly" communities and how to use all possible resources to encourage them.

Florida

One would expect the nation's "oldest" state to be a leader in elder services. Not surprisingly, Florida is on the cutting edge, both at the state level through the Florida Department of Elder Affairs, and at the local level with such entities as the City of Miami's Office of Elder Affairs. Florida's work in this field long has been supported from the top. Governor Jeb Bush is not the first to realize the impact of aging on the state, but he has stated a compelling vision of commitment. He seeks to make Florida "a community for life: elder ready, child friendly, family focused."

The Elder Affairs department reorganized existing state and federal programs into an agency to "advocate for and serve Florida's elders, to promote and implement long-term care policies and procedures that are elder friendly, and to plan, coordinate, administer and initiate programs and services that empower elders and their caregivers to age in place with dignity, security, purpose and in an elder-friendly environment."

Eleven Area Agencies on Aging provide or contract out for nearly all of the services. (Arizona also has Area Agencies on Aging that are funded through the *Older Americans Act*.) In 2001–2002, the Department of Elder Affairs had $310 million to work with and 374 full-time staff.

The Florida Elder Ready Community Report Card

The Elder Ready Communities Initiative "recognizes how valuable elders are to Florida, yet how much preparation is needed for our state and America to be ready to meet the collective needs of the burgeoning elder population."[90] The effort seeks to publicize the need to prepare and realizes that "most of the planning, ordinances and characteristics of a community that can make it elder ready are often 'invisible' and are mainly decided at local levels." The initiative will provide information and a checklist to communities, and designate communities as "elder ready." The Elder Ready Communities Report Card stands out as a truly grassroots tool. The easy-to-use survey systematically rates everything from traffic lights to the extent to which local government and businesses are "elder friendly." Land use and zoning get the same treatment.

St. Augustine and Miami are the first cities to participate. Similar report card tools are on the drawing board for frail elders and rural areas.

City of Miami

The City of Miami includes an Office of Elder Affairs in its Neighborhood Services Department to "assist community service providers, elder advocates and others in improving the independence and quality of life of the City's elder residents by improving accessibility and availability of programs and services." Largely an information and referral service with in-person, online and telephone access, the office also presents workshops and coordinates a volunteer corps to help elder residents to maintain their property and correct code violations.

Minnesota

Minnesota also has mapped out initiatives to respond to an aged future. The Minnesota Board on Aging and the Minnesota Department of Human Services joined forces for the *Aging Initiative: Project 2030*. This effort, which began in 1997, addressed:

- Increased personal responsibility to save and prepare for retirement and old age
- Expanded emphasis on personal responsibility for long-term care planning and health promotion and maintenance
- Increased "age-sensitive" physical, service and social infrastructures at the community level, including wise land use, life-cycle housing, responsive service delivery systems and strong social ties within communities
- Continued strong economic growth within the state, including creative use of the aging population, both in the workforce and non-paid roles[91]

Part of the effort included a report by the Citizens League in 1998 based on a series of public forums. *A New Wrinkle on Aging*, in addition to addressing workforce implications and potential approaches to long-term care, described "life-cycle communities" or "neighborhoods and cities that are sensitive to and provide for the needs and wants of all people."

The project answered the question: What will communities look and act like in 2030 in terms of a growing number of elders?

1. More Minnesota communities in 2030 will be truly livable for all age groups; they will be trans-generational and life-cycle in nature, offering diverse choices that provide for the future needs of all residents including older people.
2. Communities in 2030 will support the ability of older people to live independently longer.
3. Communities in 2030 will offer a wide array of volunteer and social interaction opportunities for all community residents including seniors, that will help build the personal and social relationships necessary to create support networks for people of all needs and abilities.

The recommended first steps towards these goals included such items as reviews of zoning ordinances that preclude mixed used development and working with growing communities to plan for an elder future rather than just focusing on today's customers. The recommendations also urged planners to ensure easy access to the information and technology that will support independent living.

Local Government

Despite the importance of addressing aging issues at the state level, local governments and institutions also play critical, immediate roles. Across the country cities and neighborhoods are rising to the challenge of accommodating elders. Baltimore is certainly one of them. Activities over a decade pushed Baltimore toward being elder friendly. Starting with public safety issues, city leaders soon learned that much more could, and should, be done. A "senior summit" identified older residents' concerns and aired their ideas for better bus schedules, more accessible, affordable cultural activities and a broader range of housing alternatives. Baltimore's "organizing theme" was "older adults' desire for continued independence."[92] In time, Baltimore provided better transportation access and discounts, increased penalties for crimes against elders, changed police training to help new officers respond better to elders, reduced bureaucracy in health services and planned intergenerational arts projects.

Florida Communities Can Determine Easily if They Are Elder Ready as Shown in this Quality of Life Survey Excerpt:

Can you walk or can you obtain transportation from most dwellings to:

Banks
❑ Yes ❑ No ❑ Needs Improvement

Barber/beauty parlors
❑ Yes ❑ No ❑ Needs Improvement

Theaters
❑ Yes ❑ No ❑ Needs Improvement

Restaurants
❑ Yes ❑ No ❑ Needs Improvement

Coffee shops
❑ Yes ❑ No ❑ Needs Improvement

Dry cleaners
❑ Yes ❑ No ❑ Needs Improvement

Supermarkets
❑ Yes ❑ No ❑ Needs Improvement

Source: Florida Department of Elder Affairs.

There is no model yet for what the population of older Americans might accomplish in work, in the arts, in community building, in teaching, in politics, in grandchild-care... This is the unknown factor in all of the discussions about economic and social challenges related to aging. We are just beginning to invent these possibilities, with an eye toward ensuring that as our society ages, it grows wiser.

Aging in the 21st Century Consensus Report, Stanford University.

There are many other good grassroots examples. In Pittsburgh and bedroom communities south of Seattle, new facilities combine elder centers, libraries and other services. In Elizabeth, New Jersey, a branch library forms the hub for a senior center, preschool and clinic. Health care services and a library share space in Houston as well. A center in Illinois borrowed the ideas behind the nation's best-known coffeehouse chain to build a sense of place and an attraction for elders. Nurses in parishes and congregations now bring preventive health care and information to members in many communities, including Tempe. At seven sites in Tempe and south Scottsdale, the Tempe Community Action Agency's senior program blends health programs, screenings, activities (such as "Computers for Fun" and "Genealogy for Seniors") with an affordable, nutritious and social senior lunch program.

Seattle and King County serve elders through the "Gold Card for Healthy Aging," which combines several traditional elder services into a one-stop option. The Gold Card is available to anyone age 60 or older who lives in the greater Seattle area. It publicizes the free Senior Information and Assistance telephone number and **www.4elders.org**. Merchants provide discounts to cardholders. The barcoded card functions as a public library card and provides admission to senior nutrition programs.

As more is learned about the connection between the ability to get up and go and health, mobility becomes less about transportation and more about safety and quality of life. A U.S. Department of Transportation representative, speaking at a national conference recently sponsored by the Maricopa Association of Governments Elder Mobility Task Force, said that traffic fatalities among older people could triple by 2030. That is just one reason that the federal department has made the theme of its seven-point national plan "safe mobility for life" with goals for better public transit and safer cars. Arizona is one of the few states with a "mobility plan" that addresses elders' needs and is recognized by the transportation department. To continue its work on elder mobility in car-crazed metro Phoenix, MAG has budgeted $400,000 for a one-stop source of transit and transportation information for elders and others.

Phoenix and Tempe have taken some steps as well. The two cities have implemented traffic strategies that may enhance mobility for elders. In Tempe, traffic engineers replaced street markers with big bright signs for easy reading. Phoenix, in addition, will install 870 such signs over the next five years. In addition, timers on downtown Phoenix traffic signal "walk" signs tell pedestrians how many seconds they have to get across the intersection. Measures like these are particularly appropriate in Arizona. The state ranks about average in most of the leading causes of death, but is significantly higher in senior automobile fatalities. Arizona unfortunately placed among the top five states in 1997.[93] Also as University of Arizona transportation expert Sandra Rosenbloom has documented, elders are driving more and driving farther. The trips per driver increased 77 percent between 1983 and 1995 for older drivers, and the average vehicle trip length was 13 miles.[94]

Driving is a way of life for most Arizonans, as are neighborhoods of single-family houses. As urban experts have discussed repeatedly: "The low-density fabric of the new urban Southwest is far from perfect. Many neighborhoods are bleak garage-scapes of identical homes distinguished only by the colors of the cars in the driveway or the shape of the single window facing the street. The great boulevards of the nearly endless grid are often lined with parking lots, separating the citizens of the community from whatever kernels of architecture there may be. Many people do not know their neighbors until they get together to complain about the new development being proposed behind them."[95] Traditional housing tracts lack housing choices. Thus, if an older person or couple wants to "downsize," moving to another community is often the only choice. This, according to geographer Patricia Gober, "reinforces the tendency to age in place, which, in turn, means that young families seeking family housing must look farther and farther out at the urban fringe. Aging in place also leads to the concentration of elderly in older established neighborhoods...These neighborhoods, combined with newly built retirement communities at the urban fringe, lead to a high level of residential segregation among the elderly and cuts down on intergenerational contact."

The trend fortunately is increasingly away from age-segregated communities to those that embrace all ages. Communities that offer a full range of housing, transportation options and convenient services are coming back into vogue. The Agritopia project in Gilbert supplies an example of the so-called "new urbanism." This movement heralds a return to the traditional structure of a community, with mixed-priced housing, narrower streets, smaller yards but larger commitments of land for greenspace, walking paths and community centers. On the former Gilbert farm, many types of houses will be situated around a center that emphasizes community. Fences won't separate neighbors from one another, and walking from place to place will be encouraged. This may be a good omen for Arizona.

Elder Friendly Arizona Style

ASU nursing professor Carol Long's research identified six "Cs" that help to define what an elder-friendly community in Arizona could feature.

Table 15: The Six "Cs."

Approach	Local Examples
Community Connections *Linkages established among different interests to find solutions to pressing problems*	A rural Arizona hospital established teams among the medical and nursing staff to assist elders after they left the hospital. Metro Phoenix health care providers formed partnerships to streamline paperwork and provide "one-stop shopping" for care. A nonprofit organization in rural Maine pioneered shared rides since traditional transit for elders would not work.
Capacity Building *New resources for problem solving throughout a community*	Community and hospital workers in a rural Arizona community reoriented programs and resources to deal with mental health problems for which there previously had been no local services. Eight New York communities joined together to make their region more elder-friendly through a concrete plan and lead agencies.
Communication *Enabling consumers to make informed choices about health care and other issues and take advantage of opportunities for service*	Workshops and seminars in Miami on insurance coverage and supportive education for informal caregivers on home safety assessment, nutrition and other practical topics support caregivers. The Experience Corps in Washington, D.C. mobilizes elders to mentor children and youth organizations. Arizona Attorney General's Senior Service Center offers in-depth information on fraud prevention and other issues.
Continuum of Care *Providing appropriate services to individuals as they progress through various stages*	A rural Arizona hospital developed a palliative care unit to compensate for a lack of local hospice care. Time Dollar Institute, a part of the Brooklyn-based Elderplan HMO, enlists members to care for each other and earn "time dollars" that can then be used for services, medical equipment, or special events.
Care Management *Strategies from case management services for at-risk individuals to disease management*	Through ElderReach a 17-county area around Cincinnati created joint mental health and substance abuse services for elders after working together to identify the need. A suburban Arizona hospital holds monthly case management consortium meetings for health care providers across the community, such as the Arizona Long-Term Care System, home health care agencies and long-term care facilities.
Creativity *New strategies to address tough issues*	An Arizona hospital telephones all patients within 48 hours after they go home to see what else they might need. Others offer transportation programs for homebound elderly patients or follow-up care in the emergency department. The idea of several generations under one roof is coming back through co-housing developments in Prescott and other areas. Central features such as a kitchen and community facilities in addition to single-family homes, duplexes, or apartments make this living arrangement different.

Source: *Meeting Community-Based Needs in Arizona,* 2001.

Elder-friendly communities are good communities. What older people want is in many ways what most people want — affordable housing, access to health care, clean, safe streets, good jobs and service opportunities, and a rich array of social and cultural activities.

Grantmakers in Aging.

Of course, home health care and technology promise more ways and better tools for making communities elder friendly and livable. Combined, home health care and technological innovation can increase capacity to remain independent, living at home with an acceptable quality of life and needed health care. Emphasis on user-friendly home technology and home health care makes best use of institutional resources and scarce health professionals. These are important elements of a community's capacity to care.

Healthy Communities Promise Happy Endings

Building community capacity to meet the health needs of an aging population approaches the future positively and realistically. Embodied in the healthy communities approach is reinforcement of the desire for personal independence and belief in preventive living arrangements and practices. Additionally, because it stresses community collaboration, it patches together existing resources and refocuses them on future challenges of the elderly. All local communities are composed of multiple governments, social service organizations, businesses and other organizations that have resources and missions that, if coordinated and developed, represent significant capacity.

The big "if" is coordination and collaboration. These frequently prescribed treatments do not come automatically and, in fact, require sustained, committed leadership and investment to take hold in meaningful ways.

Many believe that to compete and prosper, communities of the future will need to solve capacity issues through collaboration, innovation and prudent resource management. These processes will require a realistic vision of the future based on understanding the needs and resources associated with a changing age structure. Leadership that effectively translates these messages plays a critical part in community capacity development.