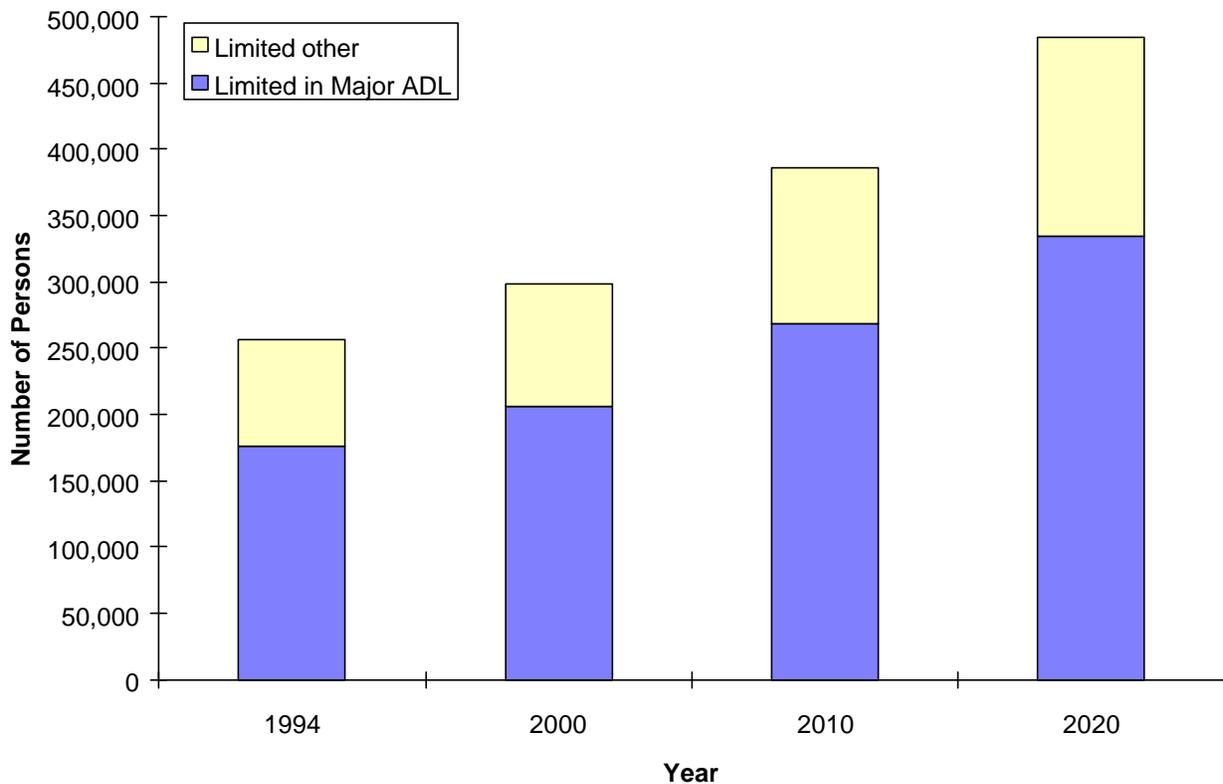


Section III: Stresses on the System

An effective chronic care system must adequately respond to the needs-- both health care and other needs-- of people with chronic conditions. Stresses on the system can come from currently unmet need or from events in the future that increase or change the need for care and services. This section attempts to identify areas where such stresses exist today or might be anticipated in the future.

Current Unmet Need

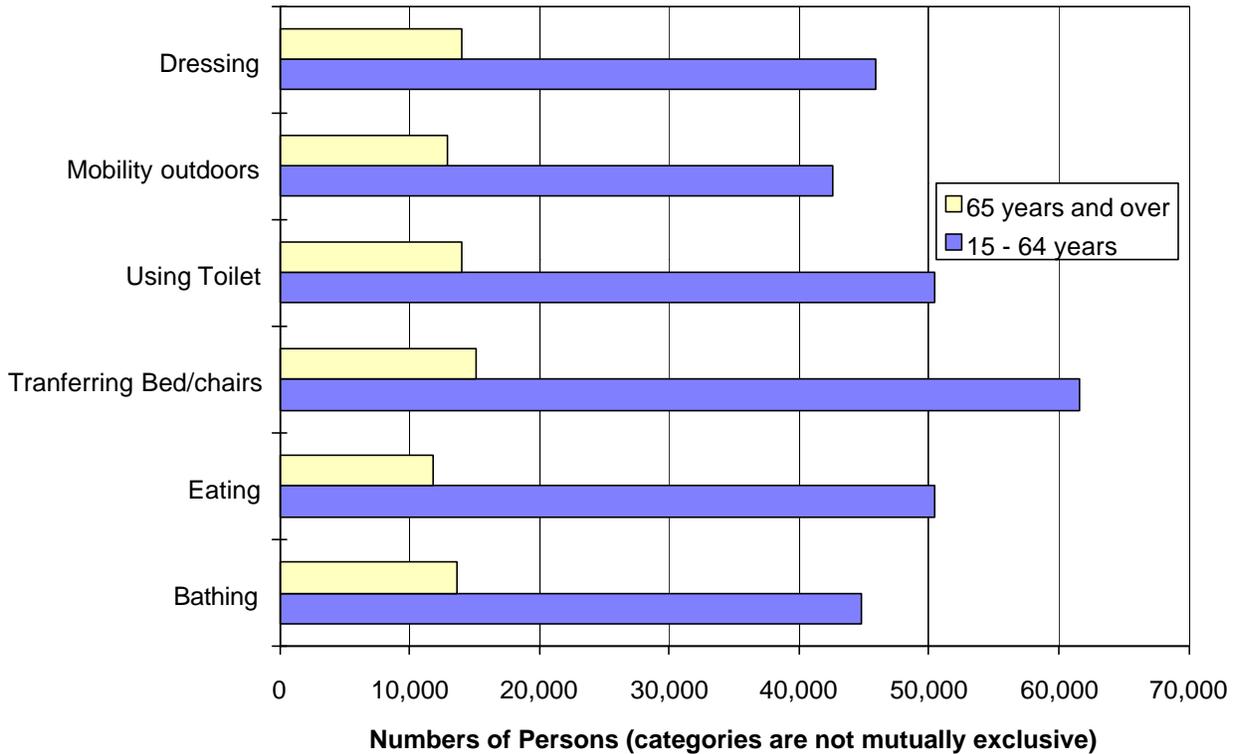
Figure 27. Estimated Numbers of Utahns with Limitations in Activities of Daily Living: 1994 and Projected to 2020.



Source: Projections are based on National Health Interview Survey data and Utah's population projections.

An estimated 140,000 Utahns (7%) have limitations in activities of daily living (1996 Utah Health Status Survey). The method used to estimate that number in Utah probably substantially underestimated the number of such people. Estimates from the National Health Interview Survey (NHIS), would suggest that about 270,000 (13.4%) Utahns had such limitations in 1996. If the percentages of Utahns with ADL limitations at various ages remain the same as in the NHIS, the number of such Utahns will increase to 484,000 by the year 2020 (Figure 27).

Figure 28. Estimated Number of Persons with Unmet Need for Assistance with Activities of Daily Living. Utahns aged 15 and Over, 1994.



Source: RWJ. Chronic Care in America: A 21st Century Challenge (data from Springfield Massachusetts Study of Populations with Disabilities, National Health Interview Survey, Utah Population Projections).

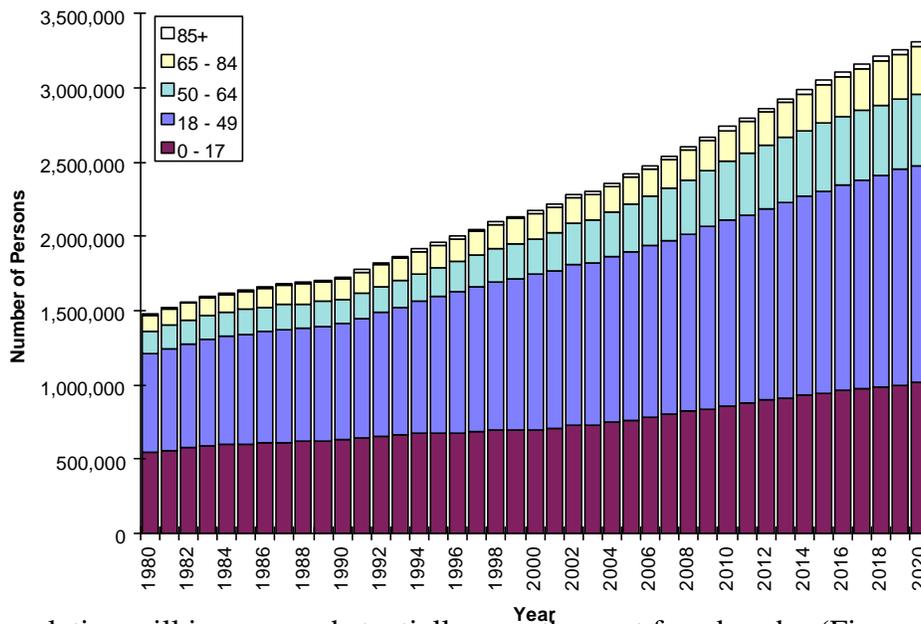
No studies in Utah have examined how well the needs for assistance of people with activity limitations are being met. A study conducted in Springfield, Massachusetts suggested that substantial proportions of such individuals have unmet needs for assistance. If the unmet need for Utahns is similar to what was found in that study, a substantial number of Utahns have unmet needs for assistance (Figure 28). People over the age of 65 are more likely to have activity limitations than are younger people, but there are substantially more people in the younger age group and younger persons with activity limitations are often more likely to have unmet needs.

The data from that 1994 Massachusetts study may not be applicable to the Utah population. Additionally, they cannot be used to measure improvement or the effects of demographic or system change on the extent of unmet need. **If the performance of the chronic care system in Utah is to be meaningfully assessed, information on how well needs for assistance are being met in Utah will be needed.**

Presently available data do not allow us to identify accurately the medical or other conditions that cause loss of independence and need for long term care. If we had that information, we might be able to provide improved care that would prevent or delay that need.

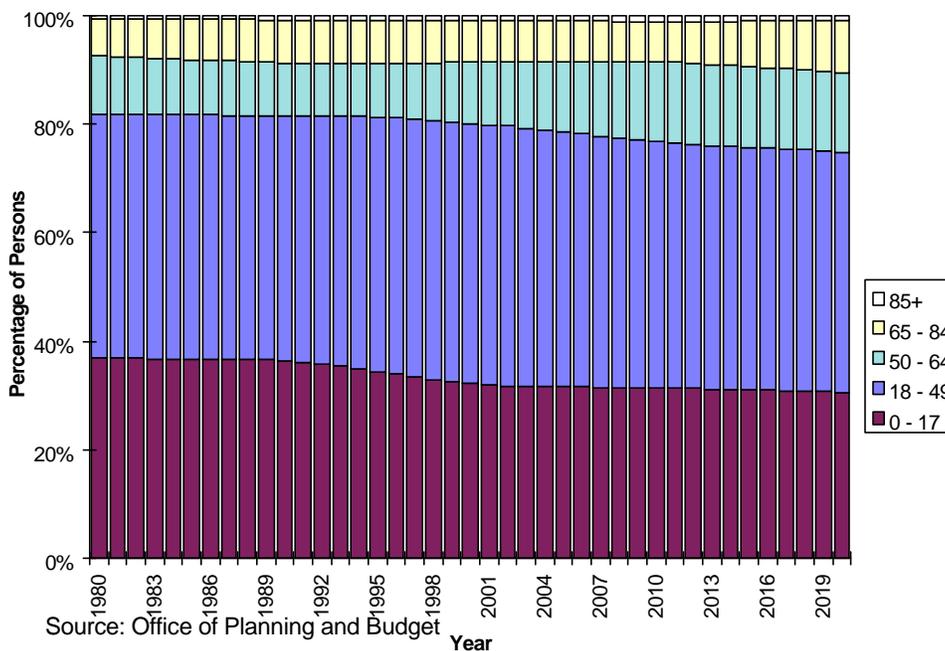
Projected Change in Need

Figure 29. Utah Population by Age Group Projected Through 2020.



The Utah population will increase substantially over the next few decades (Figure 29)-- it is projected to reach 3.3 million by 2020. At that time, 352,000 Utahns will be aged 65 or over, and 33,000 aged 85 or over. The increased number of people in those age groups will substantially increase the number of persons in need of chronic care. The population in those age groups will also increase somewhat relative to the overall Utah population (Figure 30). In 1990, 9% of Utahns were aged 65 or older; that percentage will increase to 11% by 2020.

Figure 30. Percentage Distribution of Utah Population by Age Group, Projected Through 2020.



Source: Office of Planning and Budget

Financing of Chronic Care

Medicare, the principal health care insurance source for most persons over age 65, does not cover costs of outpatient medications. For many chronic conditions, medications are an important part of disease management. An example is asthma, where appropriate use of medications can improve quality of life and reduce overall medical expenditures by preventing hospitalizations and emergency room visits. This is also true for patients with other important chronic conditions, such as diabetes and heart disease.

In addition to impeding appropriate management of patients with chronic conditions, the failure of medicare to cover medication costs can shift the costs of care from medicare to medicaid (medicaid does cover costs of medicines for eligible patients). The budget for drugs in the Utah Medicaid program has increased substantially in recent years (Figure 31).

Figure 31. Outpatient Prescription Drug Expenditures, Utah Medicaid Program, Fiscal Years 1992 - 1996.

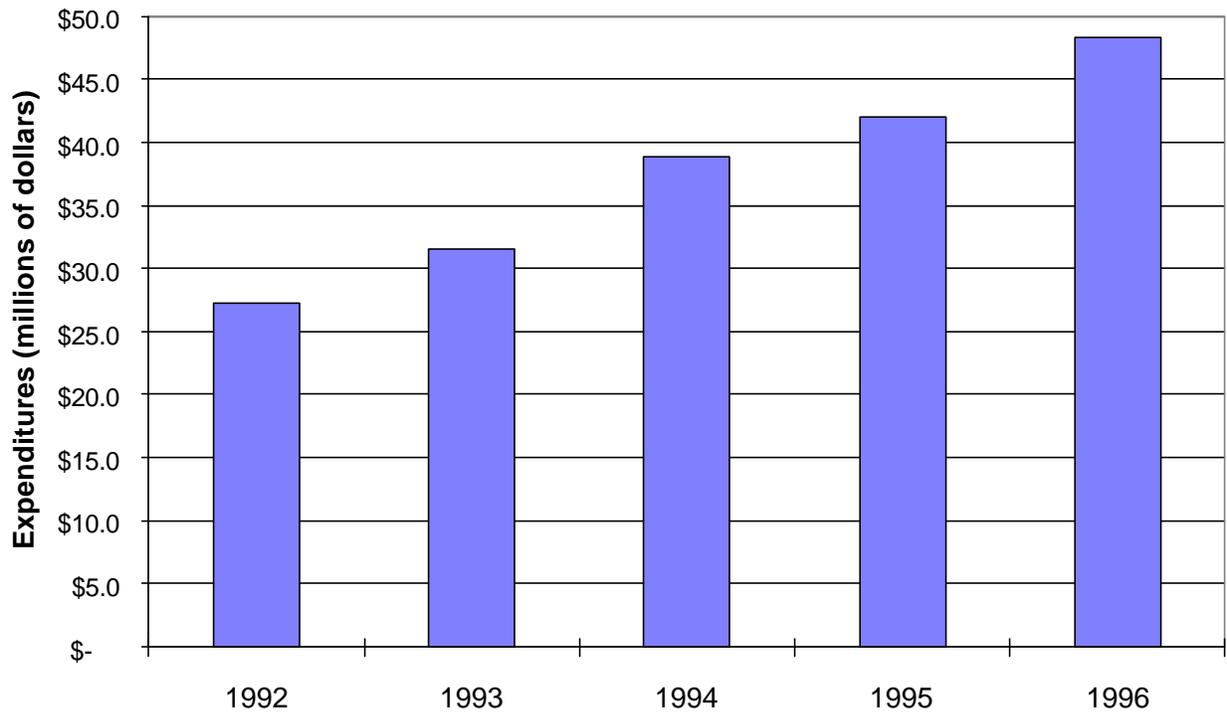
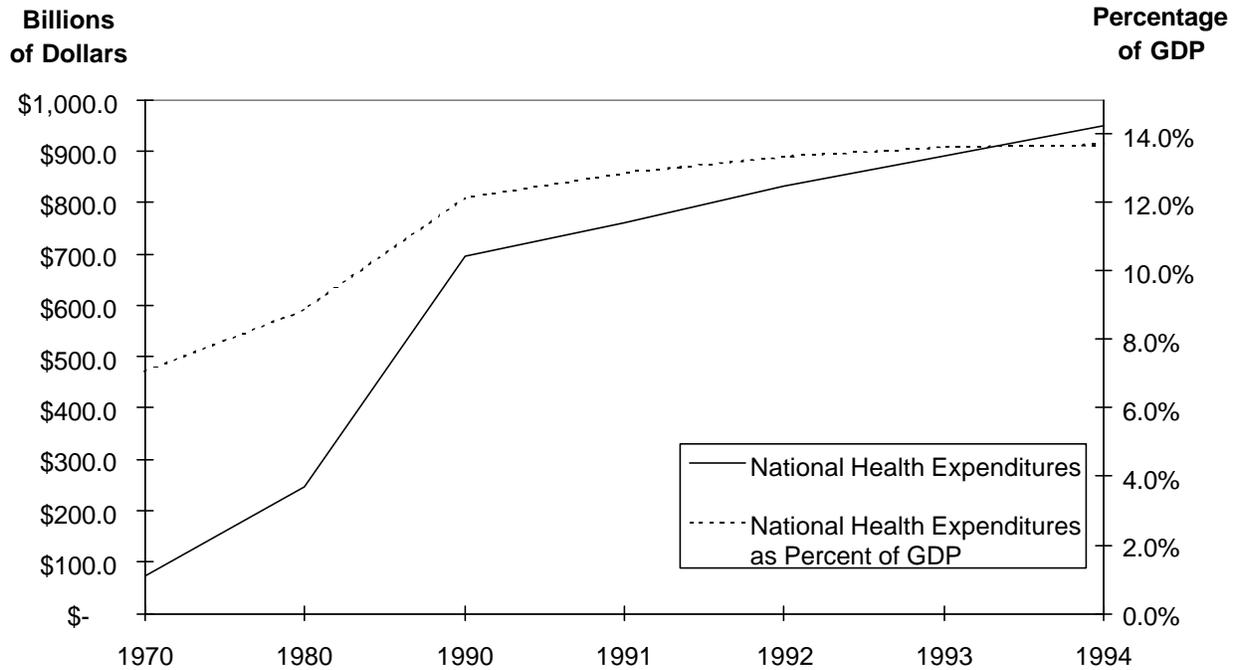


Figure 32. National Health Expenditures, United States, Selected Years 1970-1994.

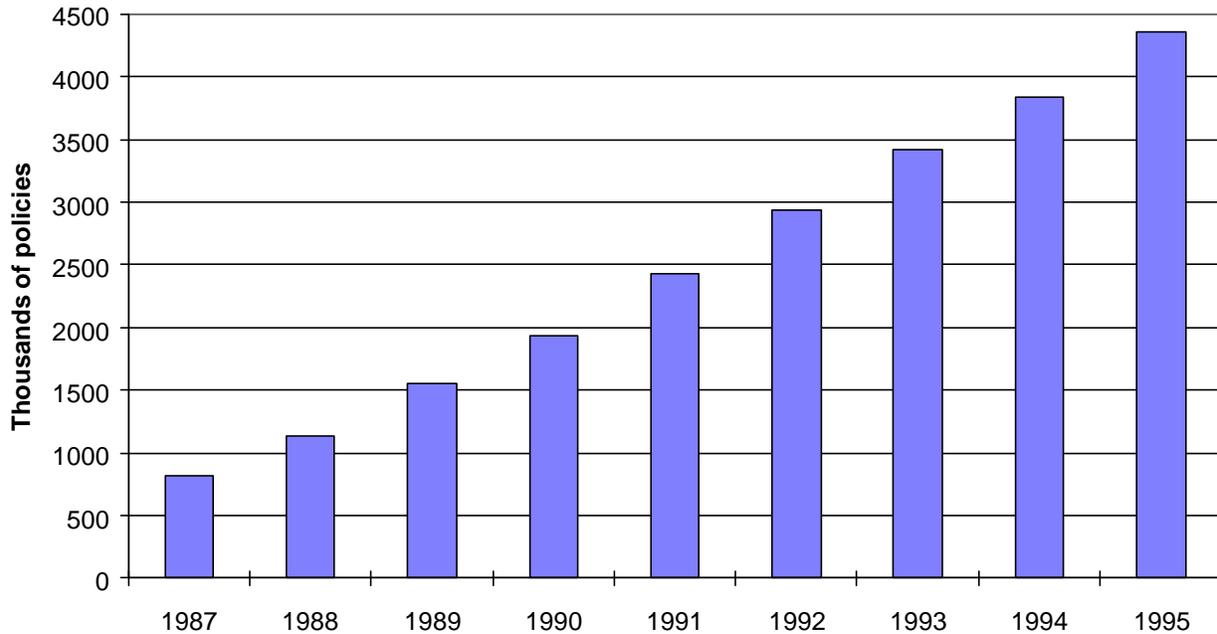


Source: Levit KR, Lazenby HC, Sivarajan L. Health care spending in 1994: slowest in decades. Health Affairs 1996;15:130-144.

Health care expenditures have increased substantially during the past 2 decades² (Figure 32). That increase has led to attempts to control costs, including various methods to limit health care utilization. Those methods often suppress appropriate as well as inappropriate utilization³. To the extent that health care expenditures approach the maximum that society is willing to pay, resources to meet the increasing demands for long term care will be limited. Also, methods to limit utilization may adversely affect the care provided to persons with chronic conditions.

In order to track expenditures for long term care, standards will need to be developed that specify the conditions, diagnoses, encounter types, and other services that are part of long term care. Those standards must allow the assembly of expenditure data from different data sources covering different parts of the long-term care system, including medicaid, medicare, hospital discharge, and private insurer claims.

Figure 33. Cumulative Number of Long-Term Care Insurance Policies Sold, United States, 1987 to 1995.



Source: Coronel S, Kitchman M. Long Term Care Insurance in 1995. Health Insurance Association of America. Washington, D.C.. May 1997.

Increasing numbers of individuals are purchasing insurance policies to help pay for the costs of long-term care (Figure 33), but the percentage of persons who have purchased such insurance coverage remains low. In Utah, as in more than half of all states, the cumulative number of such policies sold equals 6% or less of persons aged 65 or over⁴.

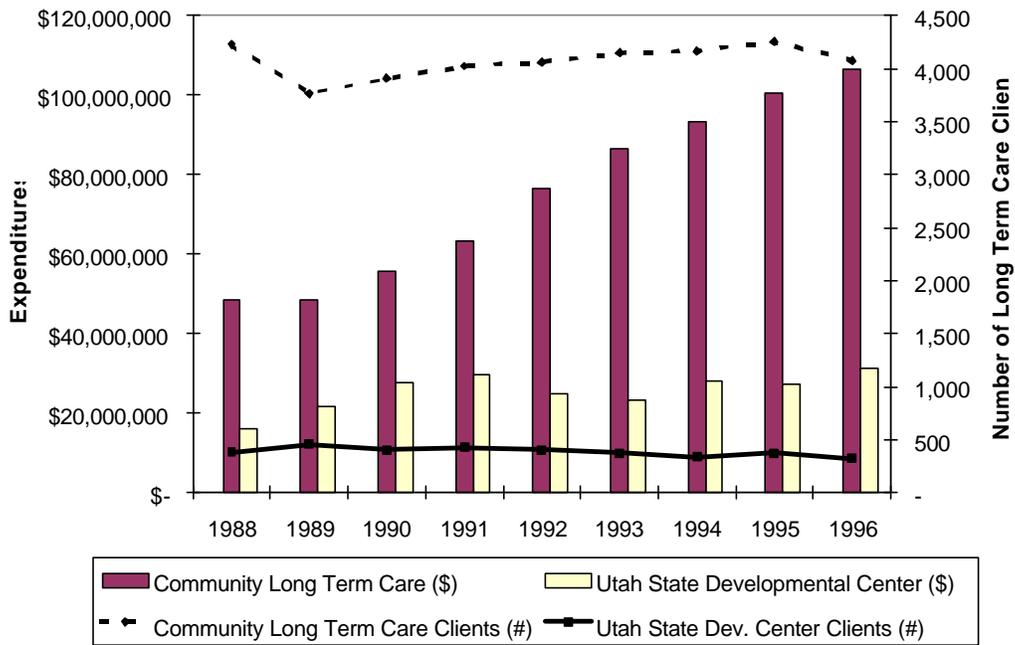
Long-term care insurance has evolved from limited to fairly comprehensive plans; all plans offer nursing home, home health care, adult day care, respite care, and alternate care services; some offer hospice care as well.

The 1996 *Health Insurance Portability and Accountability Act* (HIPAA) included consumer protection standards for long-term care insurance and clarified federal tax treatment of such insurance. This law may result in increased awareness of long-term care insurance and make it more financially attractive, leading to continuing market expansion.

Growth of private long-term care insurance may lessen reliance on publicly funded programs.

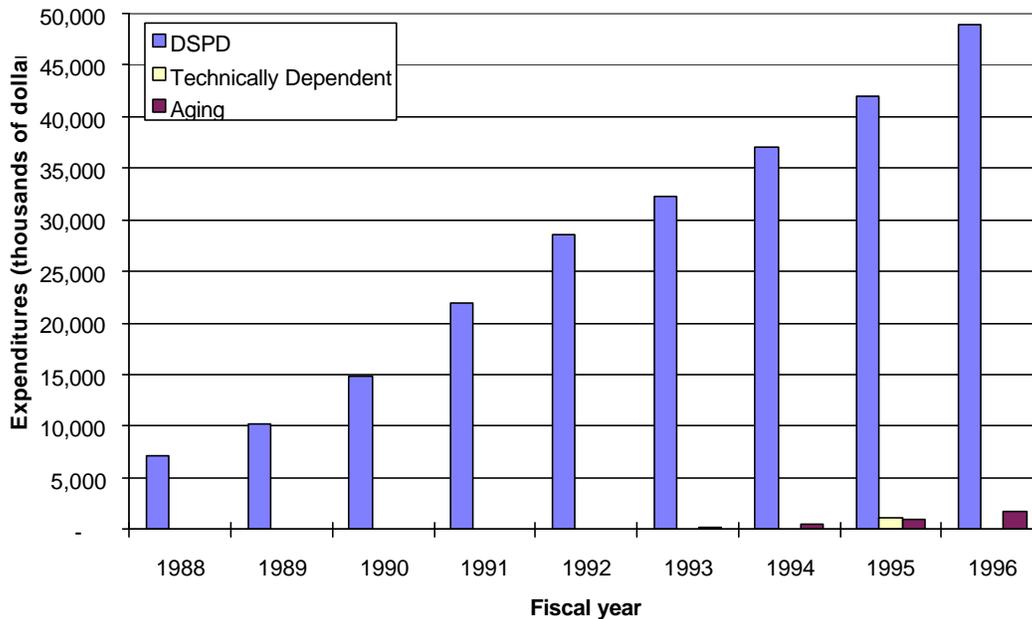
Medicaid expenditures for long term care have increased substantially, particularly in the area of community long term care services. This increase has occurred without a substantial increase in the number of clients served (Figure 34).

Figure 34. Medicaid Expenditures for Long-Term Care, Utah, FY1988 - FY1996.



The Utah Medicaid Program has obtained waivers that allow provision of home and community based care for persons who would formerly only have been able to obtain Medicaid reimbursement for nursing home care. Substantial growth has occurred in the Division of Services for People with Disabilities (DSPD) waiver (Figure 35). The Administration on Aging recently rated Utah as “average” regarding its progress toward a home and community-based service system for aging populations.

Figure 35. Medicaid Expenditures Under Three Home and Community-based Care Waiver Programs. Utah 1988 - 1996.



An important challenge for the system will be to provide support for family and other unpaid care givers, rather than substituting a paid or public system of care giving.

Managed Care System and System Capacity

The most important challenge in this area is to build an effective and efficient “chronic care system”. The U.S. medical care system is oriented more toward acute and episodic care than toward provision of care for chronic conditions. Such care requires greater coordination among providers, and a different approach to storing and using information.

Managed care is an increasingly important component of medical care financing and delivery in the United States. Managed care has potential to both benefit and harm the care provided to persons with chronic conditions. Managed care can allow more systematic development of care delivery systems, including improved referral and consultative mechanisms, and information systems that track patients’ outcomes and care over time and across providers. On the other hand, managed care can impose barriers to utilization that do not effectively discriminate between appropriate and inappropriate utilization.

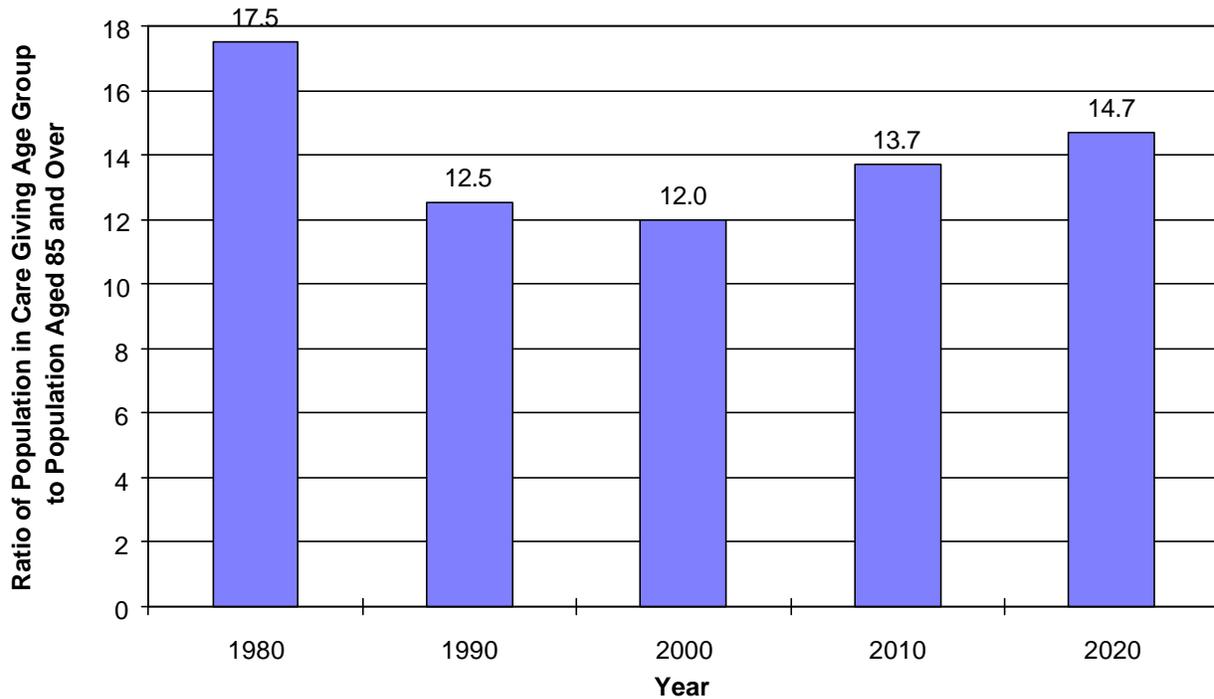
Capacity to provide long term care has increased substantially in Utah -- both nursing home beds and home and community services.

In 1983, 39 home health care agencies were licensed by the Utah Department of Health. In 1997, that number had grown to 103 agencies. An additional 107 branch or satellite offices were operating under the licenses of those entities. We have limited information on the actual service capacity of those entities, however.

The number and occupancy of nursing home beds that are certified for Medicare/Medicaid reimbursement is tracked by UDOH. That number decreased relative to the number of Utahns age 65 and over during the 1990s, due to a moratorium on certifying additional beds for Medicaid/Medicare reimbursement. Numbers of nursing home beds not certified for Medicaid/Medicare are not tracked by UDOH; the number of such beds is believed to have increased substantially.

While long-term care capacity has increased in Utah, the range of options (such as assisted living) and financing for those options have not kept pace with the needs and preferences of the elderly and others who need such care.

Figure 36. Ratio of Persons in Care Giving Age Group to Persons Aged 85 and Over. Utah 1980 - 2020



Source: Utah Office of Planning and Budget; Care Giving Age Group is Aged 50-64 years

Much care for persons with chronic conditions who require assistance with activities of daily living is provided by family or other unpaid care givers. Changes in the economics, social characteristics, and demographics of the Utah population are substantially changing the availability of such care givers.

The traditional care giving age group is age 50 to 64 years. Demographic pressures on this care giving group will be less for Utah than for the United States. In the United States as a whole, the ratio between that care giving age group and the age group most often requiring care (age 85 and over) is projected to decrease from 11 to 1 in 1990 to 6 to 1 in 2030 and 4 to 1 by 2050. In contrast, that ratio is projected to increase somewhat in Utah, from 12 to 1 in 1990 to 15 to one in 2020 (Figure 36).

A 1996 national survey⁵ found that 23% of US homes contained a “care giver”, someone who had provided care, such as dressing, bathing, toilet needs, or feeding, to a relative or friend age 50 or older within the past year. Three quarters of those were “currently” providing such care. Three quarters of those care givers were women, 41% also had a child under 18 in the household, and 64% were employed (52% full-time).

Care givers frequently experience conflicts between work and their care giving responsibilities, requiring switches from full-time to part time, changes in work schedule, or a leave of absence. A positive finding of that survey was that most care givers found their employer sympathetic to their needs.

The increasing participation of Utah women in the paid labor force has made it more difficult for women to assume that traditional care giving role. In 1950, only 24% of Utah women participated in the paid labor force, compared to 30% for the United States. In 1994, 66% of Utah women participated in the paid labor force, compared to 59% for the United States.

Certain types of providers will be particularly important for an effective chronic care system, such as physicians trained in internal medicine and geriatrics, and geriatric nurse practitioners. The effect of managed care and capitated payment systems on the numbers of such providers is not known. We do not have a mechanism to track numbers of such providers according to specialty in Utah.

Obtaining information on the health status of persons receiving long term and chronic care will be important for evaluating the impact of changes in the care system. Such data should be collected as part of service delivery.