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# Most American Children Will Never See a Geriatrician

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The question is: Why won't American children be seeing a geriatrician? The answer has two sides. On one side is the supply of geriatricians, which is decreasing at an alarming rate. On the other side is the demand by patients who are now baby boomers turning 65, but who may be at risk for premature death brought on by lifestyles that included childhood obesity, tobacco abuse, and other unhealthy habits. What's more, their children and grandchildren are following in their footsteps. Now is the time to teach preventive care to ensure that today's children reach their senior years in good health. It's also the time to ensure that physicians have the proper training in geriatrics to ensure health care for these later generations.

## Supply Side

The American Geriatrics Society (AGS) describes geriatricians as physicians who are initially board certified in family practice or internal medicine and have been required since 1994 to complete fellowship training in geriatrics beyond their residencies. While geriatricians can serve as either primary care providers (PCPs) or consultants to other PCPs for the sickest patients in Medicare, they typically serve these patients in either setting across the full continuum of care.

Geriatric medicine is said to promote wellness and preventive care in older persons, with emphasis on care management and coordination, frequently involving a team of healthcare professionals. Perhaps it is just as important for geriatricians to spend some effort promoting public health resources to younger people to help lay the foundation at

childhood for healthy aging.

Unlike other specialties, most geriatricians receive all their reimbursement through Medicare; therefore, they are directly tied to the federal reimbursement rates. Currently this reimbursement system favors physicians who provide procedure-related services such as radiologists, cardiologists, and gastroenterologists rather than those who simply provide their cognitive services.

Partly as a result of this limited reimbursement paid to geriatricians, fewer than 4500 of the 100,000 general internal medicine physicians are currently certified in geriatrics.<sup>1</sup> Currently, there are just 7600 certified geriatricians in the United States compared with an estimated need of 21,000. In 2005, there was only 1 geriatrician for every 5000 Americans 65 and older—a ratio likely to worsen. The poor economics of geriatric

medicine result in an average annual income of \$150,000, placing geriatricians near the bottom of physician incomes, and resulting in a decrease in the number of physicians taking up the field. Yet in a 2002 survey geriatricians reported the highest job satisfaction of any specialty; unfortunately this does not appear enough to motivate more physicians into the specialty.<sup>2</sup>

Geriatrician training recently had an even greater setback when funding for geriatric education and training under Title VII of the DHHS HRSA Public Health Services Act (US Department of Health and Human Services, Health Resources and Services Administration) for fiscal year 2006 was eliminated. The number of physicians trained in geriatrics each year is less than 350, a figure that doesn't match the number of geriatricians who are retiring from active practice.<sup>3</sup>

The number of geriatricians will never likely be sufficient to provide all the needed primary geriatric care. But obtaining geriatric training is becoming a difficult secondary goal for PCPs to reach.

PCPs are also poorly trained in geriatrics. In recent surveys by the *Journal of the American Medical Association*, many physicians reported being unprepared to deal with end-of-life issues, communicate with family caretakers, or deal with depression or other issues of aging.<sup>4</sup> This training deficiency was highlighted in results of a survey of

geriatric medicine curricula offered by internal medicine residency programs. The availability of faculty with geriatric expertise varies across internal medicine residencies, and residents in some programs spend little time in specific, required geriatric medicine clinical experiences.

Targeting residents with training in geriatrics isn't enough either. Many community-based internists and family physicians lack familiarity with geriatric knowledge and best practices, but are battling overwhelming fiscal and time restraints to expand their skills and improve their care of older adults. A review of the literature confirms that the most effective methods of changing physician behavior involve multiple educational efforts such as written materials or toolkits combined with feedback, individual educational visits, or small-group training.<sup>5</sup>

The importance of geriatric training for physicians was not lost on participants of the 2005 White House Conference on Aging, who acknowledged the need for more education and training of health professionals in geriatrics as 2 of its top 10 recommendations.

While the message that more geriatricians are needed to treat our aging population has met with great resistance both politically and practically, perhaps there is a role that should be carved out for geriatricians as educators. The message more likely is that issues relevant to older patients must be incorporated into medical education, as was done years ago with women's health issues. This message is principally for internal medicine and family medicine. But this group receives so many mes-

## **T**he trend among young Americans is toward less healthy lifestyles.

sages that unless we geriatricians push our message, it will surely be lost in the noise. And it's not a matter of a special geriatrics curriculum—it's a matter of adequately training internists and family practitioners who, by definition, should be geriatricians.

### **Demand Side**

Despite the fact that the baby boomers are hitting 65 with tsunami-like force and creating a tremendous demand for geriatric services, there is an increasing public health crisis growing among our children that may prevent many of them from reaching Medicare eligibility. The problems most typically reported involve obesity and tobacco abuse.

The demand for medical services stems primarily from failures in our public health system, although this cause is seldom recognized. Instead, all too often, demand is linked incorrectly to the number of physicians in a geographic area. Such was the case in the well-reported study from Dartmouth that failed to take into account that demand was tied to public health failures such as obesity, tobacco abuse, poverty, and educational inadequacies.<sup>6</sup> Currently 3 states (Louisiana, Mississippi, and West Virginia) have a prevalence of obesity greater than 30%.<sup>7</sup> Results from the 2003-2004 National

Health and Nutrition Examination Survey indicate that an estimated 61% of US adults are overweight and 24% are obese.<sup>8</sup>

Obesity is one problem with a easily recognized cause: an imbalance between caloric intake and caloric burn. Increased portion sizes, processed foods, and sedentary lifestyle are the root causes. One need look no further than McDonald's for examples of increased portion sizes. In the mid-1950s McDonald's offered only 1 size of French fries; today that size is considered "small" and is one third the weight of their largest size. While these factors are a problem for all children, they are especially acute among poorer children of whom 20% are obese versus 15% of nonpoor children. These disparities also are seen by race.<sup>9</sup> Recommendations to remedy this problem include marketing campaigns to promote better nutrition that reach more racial and ethnic minorities in low-income communities. Because educating low-income consumers cannot remove disparities in financial and physical access to healthy food, advocates have proposed tax-related policy options to modify the food environment experienced by low-income groups.<sup>10</sup>

The serious preventive health problems associated with obesity include cardiovascular disease, type 2 diabetes, osteoporosis, depression, and breast and colon cancer. These diseases are increasingly common in the young elderly population. Obesity accounts for 61% of healthcare costs associated with type 2 diabetes; 34%, with endometrial cancer; 24%, with heart disease; and 17% with

## Stay in School and Live Longer

More education means better health. The US death rate for those with fewer than 12 years of education is 2.5 times higher than the rate of those with 13 years of education or more.<sup>1</sup> High school graduation is positively related to lower mortality rates and lower medical-care time and money expenditures.<sup>2</sup>

Education is consistently linked to longer life in every country where it has been studied. It is more important than race or income. James Smith, a health economist at the RAND Corporation suggests that a few extra years of school extend life and significantly improve health even decades later.

The American Council on Education<sup>1</sup> offers this chart of the impact of education on selected activities and characteristics relating to a healthy lifestyle.

Activity/Characteristics	No HS Diploma	HS Diploma or GED	Some College: AA or BA	BA or Higher
Have health insurance (25 and older)	76%	82%	85%	92%
Ever had a mammogram (age 35+)	45%	59%	66%	NA
Exercise/play sports regularly	26%	37%	52%	NA
Smoke cigarettes	32%	30%	18%	NA
Aware of sodium/hypertension link	27%	39%	51%	NA
Life expectancy, white men	71 years	71 years	72 years	NA
Life expectancy, white women	78 years	77 years	81 years	NA
Births per 1000 women aged 18-34	1776	1325	887	644

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hypertension.<sup>11</sup> The Harvard Center for Cancer Prevention's Web site ([www.yourdiseaserisk.com](http://www.yourdiseaserisk.com)) provides consumers with customized information on their personal health and risk for disease, and directions on a tailored action plan to lower risk for health problems. However, such health information may be inaccessible to those economically deprived people who need the information

most. It may also not reach those with less education. There is evidence that education level, independent of economic level, correlates with health (see Stay in School and Live Longer).

Like obesity, tobacco abuse is a growing problem in our adolescent population. One third of tobacco users start smoking before age 14 and 90% before age 21.<sup>12</sup> If current tobacco use patterns per-

sist, an estimated 6.4 million current children smokers will eventually die prematurely from a smoking-related disease.<sup>13</sup>

A study by Bradley Wilcox from the Pacific Health Research Institute in Honolulu substantiated the relationship between healthy lifestyle in younger years and long life. In particular, this study of over 5000 men found that only 11% lived to age 85 or older in relatively good health. The longer life of the 11% was attributed to maintaining an ideal weight, not smoking, and getting regular exercise.<sup>14</sup> Unfortunately, among young Americans, the trend is increasingly toward less healthy lifestyles, resulting in decreased life expectancy.

## How Can Geriatricians Help?

Geriatricians have several responsibilities to ensure that more Americans receive geriatric care now and in the future. Politically and professionally we need to invest energy in promoting geriatric curricula and policy making that affects our profession. As caregivers, we need to stretch our influence beyond providing care for our current elderly population to promoting healthy lifestyles among our younger generations so they reach healthy old age.

Baby boomers have dramatically changed every market they have touched. Clearly geriatric care is one area in which boomers will have lasting effects. Seniors' demands for individualized care have influenced the availability of assisted living, concierge care, and special-needs plans. But the younger generation is far less influential and informed about its future healthcare needs. We need

## PROVIDER ACTION

### Impact to You

All Medicare providers need to be concerned about the potential decrease in the number of children reaching their full potential because of obesity and other health concerns that can be prevented. Providers must also be concerned about the shrinking roles of geriatric providers.

### What You Need to Know

Federal and state programs, if directed appropriately, can increase the number of geriatric care providers and reverse the trend of childhood obesity and tobacco/drug abuse. Currently there are just 7600 certified geriatricians in the United States. Obesity rates continue to climb in our children with rates as high as 20% in the poor population and 15% reported among the nonpoor.

### What You Need to Do

Providers need to play an active role in their communities and on a national basis to push public health support for such programs as exercise and dietary programs for children and tobacco and drug cessation. In addition, funding needs to be maintained and improved to support quality geriatric care.

to focus attention on early preventive care initiatives to lay the foundation of healthy aging among our youngest citizens.

In their July 2006 report, The National Institute for Healthcare Management<sup>15</sup> outlined several initiatives to improve the health of young adults. These initiatives included:

- Increasing access to health care
- Tailoring health care to specific groups of young adults
- Providing health insurance coverage for adolescents and young adults that ensures increased access to healthcare resources
- Evaluating and documenting strategies to provide healthcare coverage to young adults
- Developing data specific to the young adult population
- Obtaining young adult involvement

This list offers several critical areas in which geriatrician leaders can play an important role.

The wake-up call for fellowship-trained geriatricians is to provide leadership that's needed to promote healthy lifestyles among our nation's children and to support training in geriatrics for current and future physicians so that geriatric expertise will be available to all American children as they become seniors.

Geriatrics is a fascinating field of medicine, currently in the midst of a great revolution. Leaders are needed to take charge—leaders who are not afraid of embracing emerging technologies and expanding the roles of nonphysician care-team members. Those who are willing to take up this charge will touch the lives of both 89-

year-old Alzheimer's patients and children coursing to premature aging secondary to their poor health habits. It is only through these efforts that senior care providers can be assured that all Americans have an opportunity to age well.

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