The Gulf in Aging's Leadership*

Summary

The United States is entering an era of mass old age without the leadership, workforce, and systems needed to manage chronic conditions and frailty. The acute-care, hospital-centered "medical-industrial" model and its financing structures have crowded out long-term care, geriatric expertise, cross-disciplinary training, and sustained community-based solutions. Training and leadership pipelines in aging administration have withered. Geriatrics is drastically undersupplied. Public health and university health programs remain siloed and accreditation-driven, limiting cross-disciplinary preparation for chronic care. Digital health innovation in aging is fragmented and constrained by acute-care reimbursement models. Communities must "turn to one another" and develop local leadership and structures to coordinate care—reclaiming responsibility for aging as a shared civic project rather than outsourcing it to hospitals, insurers, pharma, or technology firms.

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The logical question about the impact the new mass old age, with its momentous economic and social consequences, is why has no one stepped back to see that the emperor—in this case the Emperor of the Empire of Health Care—has no clothes? The answer is that nobody's looking!

A story: In the late 1950s, the federal government, foreseeing a coming age wave, funded four universities—George Washington, Michigan, Arizona and North Texas State—to prepare professionals to manage programs, services, and facilities for what was then called the elderly. Over the succeeding decades, the program at George Washington was subsumed by hospital administration; at Michigan, by public health; and the Arizona program had never gained momentum.

But at the North Texas State University in Denton, Texas, there was no larger school to eat the program. Eventually, the North Texas program boasted a renowned faculty that developed a unique multidimensional curriculum to prepare leaders in aging administration, including courses in developmental psychology over the life span, social gerontology, housing, management, accounting, and legislative programs and policy. At one point, 10 percent of the House of Delegates of the American Association of Homes and Services for the Aging were graduates the North Texas program.

*This paper includes some material from *Aging Forward: A New Path for Health, Technology, and Community,* David M. Dunkelman and Martha Dunkelman, Health Professions Press, Baltimore, MD, 2023

I graduated from this program more than 40 years ago. Recently, searching for an old classmate, I called the former director of the program. He told me that the entire program is gone, papers, documents, and all.

What happened?

- The field is no longer an attractive way to make a living, especially to young people looking at careers. As a result of the misalignment of finances, labor, regulations, and community support, few people want to work in, manage, live in, or pay for long-term care institutions. Surviving facilities turn to short-term Medicare funding to survive. The acute (short-term care) eats the chronic (long-term care). Private equity buys up community facilities and turns them over to financial managers with little training in aging.

- Of the nation's 1 million physicians, only 5000 are geriatricians—half of one percent a percent of physicians are a field of specialization needed by 20 percent of the population. There are few venues where they can utilize their expertise in managing multidisciplinary interventions.

- Public health is blind and deaf to aging. They tend to focus on traditional acute-care medicine in the community rather than understanding and exploring the fundamentally different challenge of chronic care. Recently a professional colleague told of trying to engage the dean of a prestigious school of public health in a conversation about aging. The dean responded, "What does aging have to do with Public Health?" Ask the 72 million Baby Boomers, now age 61-79.

- Health and health-related university programs remain hermetically sealed off from one another. When I proposed to a former dean of what was then an allied health school at a large university the possibility of a cross-disciplinary course to prepare professionals for the era of chronic conditions, he said that there was no room for such a course in the curriculum necessary for professional accreditations.

- State health departments remain locked into the public policy universe of Medicare/Medicaid legislation of 1965 and their leadership is hospital and physician based.

- Medicare is acute-care oriented. It pays for cures, for getting better. Once an issue is resolved, or cannot be resolved, funding for many interventions goes away. The social components of care that may delay or prevent medicalized interventions are underfunded or completely unfunded.

- Existing community programs tend to have a narrow focus on some particular aspect of aging. They are ill-equipped and under-resourced to address the complexities of frailty they find now rather suddenly in their midst. And there is little connection, one to another, that enables programs to coordinate.

- Proven successful pilot innovations in social programs for aging almost never receive permanent funding because they don't fit into existing reimbursement frameworks. This undermines innovation and the development of strong advocacy for appropriate chronic care.

- The underlying local leadership in communities that once created their own health facilities has been mostly supplanted by nationalized programs. People now treat programs for older age as they do the Department of Defense–we pay our taxes and our security is *their* responsibility. But the existing nationalized aging care programs are no longer economically sustainable. And now when many frail older people remain in the community, there is minimal local community leadership aware, engaged and armed with appropriate tools to come to the fore, to recreate local health delivery systems for the new age.

- Digital technology that has transformed so many sectors of the American economy has not yet had any meaningful impact on aging care. Digital applications in aging care tend to be narrowly focused with no orchestration of the enormous range of challenges and interventions related to aging. In some measure this is because the digital programs have been built upon and around the current government reimbursement systems that are acute care based.

This misdirection shuts out investment in more appropriate, less expensive chronic care.

- But perhaps the most fundamental reason for this failure to recognize the nature of both the challenge and opportunity in aging is dread and denial. The old industrial model facilities and programs that still survive, truly no longer appropriate for aging care, have left such an accumulation of discouraging sights, sounds, and smells, with such disastrous emotional and financial consequences, that people can't look.

And this is what they don't see:

- An assembly-line health system that utilizes set inputs produces the same, standardized results. These patterns of experience are not actually senescence (older age) but are, in reality, artifacts of an inappropriate delivery system. When we look at the inmates of nursing homes, we aren't seeing aging, we're seeing damage.

- Changes correlated with aging are not preordained, they are not "Gods will." Memory loss is not aging but rather disease. Thirty to 50 percent of the aging process can be affected by a person's behavior. People are unaware of their potential and unprepared to enhance their older years. While the existing system does little to help reset a person's behaviors, there are new programs and techniques that can foster and sustain healthy individual engagement in later life.

- The network era is delivering approaches and interventions that can be safely and less expensively delivered into older peoples' homes, where they wish to be. The collection and networking of thousands of even minute status changes can be matched in real-time to tailored interventions in a decentralized, community-based delivery system. This new reality is unimaginable to a generation whose prior lived experience is entirely steeped within the medical industrial complex.

- Even with the efficiencies of such a networked care delivery system for aging, we simply do not have sufficient financial

resources to pay for the required services. We must turn to one another.

- Communities in this networked era do have the resources to engage with the frail in their midst. It is the challenge that will enable community to once again become vital in the lives of its members. Big insurance will eventually arrive, eager to contract with community to “manage the last mile.” Community is the only group that has as its sole motivation the care of its older people.

- But there is currently no community leadership for this undertaking. That community leadership must be developed within existing functioning community entities that provide them with an understanding of the nature of the challenge, the real possibilities of a very different aging experience, and a process and structure that brings this shared enterprise to reality.

The occasional clamor in the press, the tragic stories of the horrors, the unfairness, the failure of the aging experience for both older people and providers has a national audience. Each exposé arcs across our awareness like a flash of lightning across the sky and disappears. All to no effect. Everyone—all the players in this massive demographic, sociologic, epidemiologic, economic revolution—is aggrieved. The present, outdated acute care delivery system eats up all the resources, ties up the historic healthcare leadership and they flail forward.

Nobody’s home because we’re looking for leadership in the wrong places. Jeremiads about healthcare have minimal effect because there is no audience that can do anything. All are bystanders.

The nature of chronic conditions that accompany older age, and the interventions to address them, all live in the community. The condition of our old age and the best ways to live our late years are all within community’s purview and cannot be outsourced to the medical-industrial estate, to big pharma or high tech. Only with community leadership will we awaken to the responsibility for our own older age, as we did collectively to create our current healthcare institutions, and, individually, beginning in adolescence, to take charge of our adulthoods.