ARIZONA**HEALTH**FUTURES

The Coming of Age

Four Scenarios of Arizona's Future

MAY 2002

St. Luke's Health Initiatives

The Coming of Age

Welcome to *The Coming of Age*

When a steamroller is coming down the road, you have three choices: Get out of the way, run to stay ahead of it, or lie down and get your clothes pressed.

The steamroller is age — old age — and it will remake our society in the first half of the 21st century. Everything from census numbers to personal experiences underscores the aging of our state and nation. *The Coming of Age* explores Arizona's capacity to handle this soon-to-be "gerontocracy" in positive ways.

Aging affects all dimensions of our society, but none so much as health care. Thus, St. Luke's Health Initiatives (SLHI) decided to dedicate part of its *Arizona Health Futures* program to exploring Arizona's capacity to meet the health care demands of an aging population. SLHI asked the Arizona State University School of Public Affairs and Morrison Institute for Public Policy to collaborate on The Coming of Age to inform Arizona's policy leaders and residents about these critical issues.

The Coming of Age engaged demographers, economists, public policy analysts, human service and medical professionals and citizens. Through its research, the team developed a realistic picture of Arizona's "capacity to care" for an elder population. The results of the research are presented in *The Coming of Age: Aging, Health and Arizona's Capacity to Care*.

This publication offers possible futures that are based on the research. (See **www.slhi.org** or **www.morrisoninstitute.org**.) Other project products, available on these web sites, include team members' technical papers, an interdisciplinary reference guide and results of the project's public opinion research.

We hope that *Four Scenarios of Arizona's Future* and *The Coming of Age* report spark discussion among family members and in businesses and organizations as well as city halls and the legislature. Given the best thinking of all Arizonans, new ideas will emerge on how we can — and must — prepare for an older population. Whether or not today's information age gives way to the "age of wisdom," where longer lives mean better lives for individuals and a higher quality of life for everyone, may depend on those discussions and our decisions.

Roger Hughes, Ph.D.
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Rx
PATIENT NAME: Arizona Senior
DATE: January 2013
GENERIC NAME: Health care for increasing numbers of elderly citizens.
DOSAGE: As much as you can afford, or until you just can't take it anymore.
INDICATIONS: To be used after a period of low personal savings in combination with increased health care costs.
HOW TO USE THIS MEDICATION: After a reduction in public health insurance coverage, extensive research will result in limited options. Then, work well beyond retirement age to afford rising premiums – if you can get coverage at all.
POSSIBLE SIDE-EFFECTS: Strained family relations, shortage of cash. Frequent headaches are normal. If symptoms persist, contact your local government.
DATE OF EXPIRATION: Upon the collapse of strained state budgets.
CAUTIONS: If problems persist, nurses and other health care professionals may not be available to assist you.
KEEP OUT OF REACH OF LEGISLATURE!!

The Coming of Age

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Four Scenarios of Arizona's Future

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St. Luke's Health Initiatives
A Catalyst for Community Health

ARIZONA**HEALTH**FUTURES

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Four Possible Futures for Arizona

In 2025, Arizona's population will be about 8 million. Almost 20 percent of Arizonans will be over age 65 then; nearly 365,000 residents will be over 80 years old. This is our demographic destiny.

What kind of lives will Arizona's elders lead in 2025? Will health care be affordable for them and their families? What role will technology play in health? What will be Arizona's priorities and capacity to care for its elders?

The future is never a straight-line extrapolation of the past. Instead, it zigs and zags around such a line. But we do have many clues about the future from the facts and trends we can examine today. Unforeseen events, too, certainly will affect our future, as will the conscious decisions we make now.

These four scenarios, written specifically for The Coming of Age, present possible futures for Arizona. One or more of them could very well turn out to be true. More likely, though, aspects of each will occur in the 20-year horizon between now and then.

Futurists want scenarios to provoke thought and stimulate action. Thus, we encourage you to read them as active participants in decision-making in Arizona, rather than as passive observers. The collective wisdom and will of Arizonans today will be the most important determinant of what it will really be like to be an older resident of the state in 2025.

The health care, economic, social and demographic trends that drive these scenarios are described further in the companion report *The Coming of Age: Aging, Health and Arizona's Capacity to Care*. But these four stories go to the heart of the issues that will affect every Arizonan very soon.

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Boomers Bust the Budget

In 2025, Arizona's demographic mix made the difference in the governor's race. The state's baby boomers put their political clout on display for their issue — elder health care — and their candidate — Julia Hernandez, age 56.

In the post-election analyses, campaign advisors and pundits agreed: baby boomers and their relatives determined the Election Day outcome. Winner Julia Hernandez expected this though. Her polling data showed early on that affordable, quality health care for elders would win the hearts and minds of the Arizonans most likely to vote, namely those in their 60s and 70s. The 2025 special census showed that of nearly 8 million Arizonans, 20 percent are age 65 or over.

Key Trends

- Aging boomers and their families constitute a dominant political force.
- Public revenues required for elder health care compromise public expenditures for other services.
- Health care for the aged becomes an intergenerational political issue.

But Governor-Elect Hernandez has been an elder advocate for some time. Eight years ago, as a single parent in her late forties, she put her accounting career on hold to care for her aged parents. In fact, that experience motivated her to get into politics.

The Arizona Republic told the story of her transformation from dutiful daughter to dedicated advocate to politician with an agenda.

> *"Julia Hernandez's parents moved to Prescott when they retired. As most economic development professionals know, Arizona was actively and effectively recruiting retirees then, especially the smaller communities of Payson, Williams, Lake Havasu, Globe, Green Valley, and Douglas. These growing, but still relatively rural areas, promised to provide retirees with a good quality of life. Making the case for Arizona as a place for seniors to live the good life as they aged was easy.*
>
> *Unfortunately, after lifetimes of good health, Rosa and Ernesto Hernandez started to experience problems in their 70s. Reliant on Social Security and one small pension, they depended on Medicare and an inexpensive "Medigap" policy to cover their health costs. But Medicare was not any better for Mr. and Mrs. Hernandez than it had been for millions of other Americans in recent years. It was baffling and financially unstable thanks to a flat national economy and a rapid increase in the number of beneficiaries. Since Medicare wasn't enough to cover the basics, not to mention the high cost of drugs, the Hernandezs tried to get help from various state and federal programs, but they had too many assets to qualify. Julia Hernandez's parents had to seek help from their only child.*
>
> *Julia rose to the occasion, as so many of her friends and colleagues had. But, as time went on, her parents' health needs increased to the point where they needed more than their daughter's money; they needed her to care for them. As a mother herself, Julia Hernandez became a certified member of the 'sandwich generation.' She quit her lucrative job in Tucson and moved to Prescott Valley. The change was unpopular with her two teenagers and tough financially, but it enabled her to provide care and advocacy for her parents.*
>
> *Rosa and Ernesto Hernandez lived well in their final years because of their daughter's care. She says she never regretted choosing family over career for that time, but the lessons of navigating a confusing, underfunded and overburdened health care "system" left a deep impression on her. As she said to anyone who would listen, 'There must be a better way.'*
>
> *Julia Hernandez started working for her political party and began her elected career as a supervisor in Yavapai County. Today, her eyes are on the governor's office."*

Julia's political strategy was simple — appeal to aging boomer voters and their kids by promising quality health care for the aged. These people vote, and there are lots of them. But delivering on her promise means that billions of state dollars will be devoted to health care. Such costs are so great these days that only the largest Arizona employers provide health insurance for their employees. Looking to the feds for help is futile.

As candidate Hernandez said: "Arizona's elderly population is increasing rapidly. Our families cannot keep pace with the needs of our loved ones. State government must become a better partner with families and relieve some of their financial and emotional burdens. To do this, Arizona will have to make sacrifices in other areas. As your governor, I will make caring for our state's elders my first priority."

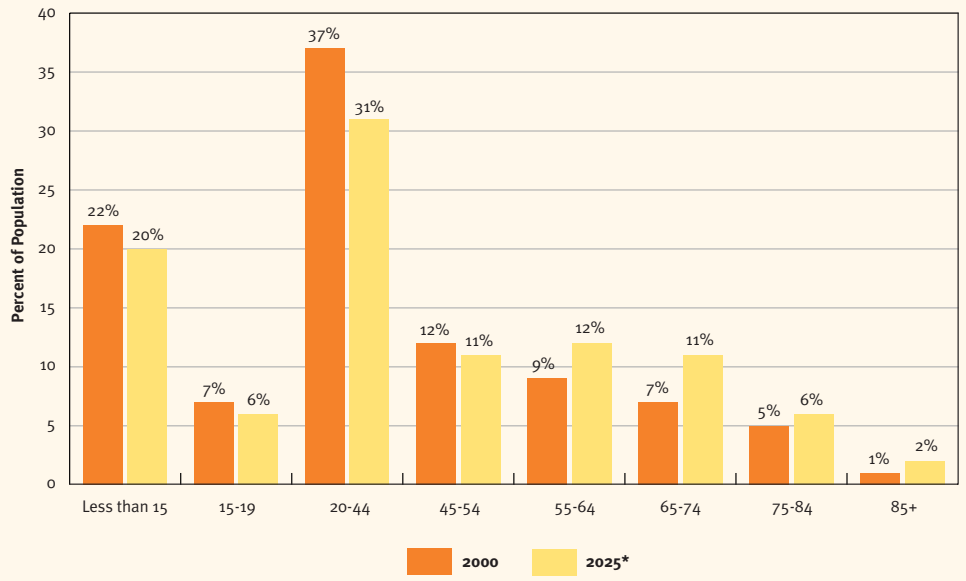
Many aging boomers, their kids and even their grandkids heeded her call to action, but others rallied against it. Many residents in Phoenix, Tucson and Mesa feel especially disenfranchised by the governor's emphasis on elder health care at the expense of other issues. Although Arizona certainly has many older residents, 31 percent of Arizonans are 20-44 years old. While many people in this age bracket have elderly parents and grandparents, they also have children and needs of their own.

Arizona's entry-level workers, young parents and professionals want more funding for education, economic development and recreation. Another sore spot is that the governor's health care program for the aged is funded, in part, by substantial cuts in education and health care for the young. The one thing everyone agrees on is that Arizona just doesn't have enough money to go around.

But, Governor Julia Hernandez is "dancing with the ones who brung her." Her life-changing experience of caring for her parents led her to a formidable powerbase — high-efficacy boomer voters and their families. Governor Hernandez is sticking to her campaign promise to improve health care for the elderly, even though it's causing other state services to suffer. In short, the governor's "politics of gerontology" is in play, notwithstanding the intergenerational conflict this policy creates.

By 2025 the Proportion of Arizonans 65 and Older Will Be Comparable to Those Under Age 15.

Arizona Population in Selected Ages, 2000 and 2025*



* Projected.

Source: Census 2000. Arizona Department of Economic Security Population Projections.

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.*

Elders Vote

In 2000, 76 percent of those 65 and over reported they were registered to vote and 68 percent said they voted. In contrast, just 49 percent of those 21-24 registered and 24 percent of those between 21 and 24 reported that they voted. Numbers improve steadily as people age with the oldest Americans voting most.

Source: *Statistical Abstract of the United States*, 2001.

Technology Enhances the Good Life

In 2025, technology is something everyone is thankful for. Gee-whiz gadgets and easily accessible information from many Arizona-based companies have dramatically improved the health and quality of life of Arizona's elders.

Even so, today's announcement is astounding. Everyone had been betting on San Diego or Austin. But Greater Phoenix it is. Science and business reporters from all over the country have come to the biomedical campus next to Tempe Town Lake to hear about the most important innovation yet in our "Age of Designer Genes."

The news release reads:

> *A drug therapy created by the Goldwater Partnership for Biotechnology prevents strokes and related complications. Arizona's premier public-private research institution is the first to develop a cost-effective, patient-specific solution to this heretofore disabling or deadly event.*

Medical professionals and Wall Street analysts take note. This is indeed the payoff that was promised when Arizona invested in biotech and biomedical research 20 years ago.

The prevention of strokes is simply the latest and greatest breakthrough though. For example, just 10 years ago, Arizona scientists led the way in integrating the study of geriatrics with research in technology and ergonomics. Now, Arizona's elders routinely use telecom tools to care for themselves in their homes. Not too long ago, elders only kept their medical records electronically. Today, computers remind them to take or change medications according to continuous readings. Most Arizonans 65 and older now experience "live" check-ups online with their doctors and health laboratories. Such distance medicine is especially beneficial to residents of small communities in Navajo, Greenlee and Apache counties.

Along with individual pharmaceuticals, smaller-than-micro surgery and telemedicine, the vast majority of Arizona seniors lead healthy lives through exercise, community service and good nutrition. After all, today's elders heard years of public health messages about how to stay in shape. Seventy-eight-year-old Antonia Smith, president of Elder Options, the state's electronic clearinghouse for information on health and technology, speaks for nearly everyone her age when she says: "We, and those who follow us, should expect life to get better and better." Antonia expects to be living well at 100 thanks to her choices and an array of drug and technological advances. What's more, her husband expects to be there with her – old, yet healthy and happy.

For a long time, especially near the turn of the century, we worried about the cost of health care for the state's older residents and a shortage of health care workers. Now we know that our concerns weren't justified.

As it turns out, technology actually drives the cost of health care down in three major ways. First, it keeps most elder Arizonans healthy thanks to accurate diagnostics and just-in-time prescriptions. Second, it reduces the need for health care workers since so many more people can care for themselves. Finally, self-care, aided by the latest technology, is a cultural norm in Arizona. People simply are expected to keep up and participate.

Key Trends

- Advances in medicine and telecommunications create great prospects for aging.
- The elderly grow old and stay healthy at the same time.
- Technology reduces health care costs and the demand for health care workers.
- Easy access to information makes the elderly sophisticated consumers of health care.

Tomorrow's Elders Are Ready for a Wired Future

Fifteen percent of today's older Americans have Internet access. Of people 65 and older, 26 percent think they are missing something by not being online, compared to 46 percent of Americans between 18 and 29. While today's elders are the least likely of any age group to go online, tomorrow's older residents are very different. Americans between 50 and 64 are among the most well connected to the Internet and are among the most likely to keep Internet access after they retire. People in this age group are more likely even than those 18-29 to have access to the Internet at home and at work.

Source: Pew Internet and American Life Project, 2001.

Arizona is lucky to have had leaders who realized that matching health care technologies with elder needs was smart policy. Professionals and consumers alike identify the outstanding work of the 2005 O'Connor Commission on Aging and the Economy as the source of bright ideas and the state's steadfast commitment.

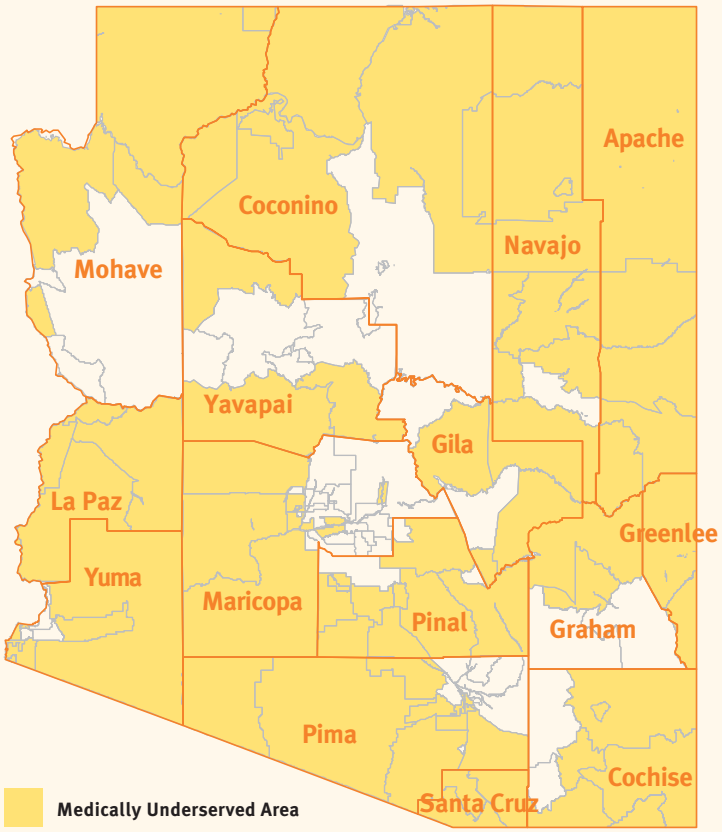
Arizona's determination to become a world leader in biosciences and health care has given almost every older resident access to powerful technologies that are tailored to their needs. It's easy to obtain information, and today's older Arizonans are extraordinarily knowledgeable consumers. Most of them can tell you where to get the best deals on anything related to health care from anywhere in the world. Sophisticated consumerism is offsetting the cost of new drugs and health insurance.

Arizona's elders now enjoy much better, longer lives with user-friendly health care technologies that reduce their need for assistance or treatment. They are smart consumers of health care. Strategic investment by Arizona's public and private sectors in health-related technologies is really paying off for people and for the state. Today's announcement is just the latest example of how such technology is, indeed, making life "better and better."

Technology and Telecommunications Can Turn the Underserved into the Served. Home Care and Self-Care are Possible Regardless of Where Arizonans Live.

Arizona's Medically Underserved Areas, 2002

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.

Technology Will Provide Better Care and More Control

Futurists say medical knowledge is doubling every eight years, and medicine and information technology are merging. The Internet has made medical information more accessible with consumers and patients now sharing experiences and information much more than in the past. Obtaining medical information is a major reason for going online according to Internet users. More than half of Arizonans now have access to the Internet at home and nearly all in one place or another such as work, school, the public library, or home. "Smart clothes" that monitor certain functions or "smart homes" that respond to what occupants do or the MIT-developed "digital Danskins" complete with mechanized joints will soon make those who may now be dependent much more independent.

In addition, futurists anticipate that:

- **By 2005, artificial blood may begin to stretch the supply of blood, which often falls far short of demand.**
- **Memory-enhancing drugs may reach clinical use by 2010.**
- **By about 2006, more than one tenth of prescriptions will be filled over the Internet.**
- **"Nutraceuticals" and "foodaceuticals" will be one of the hottest product areas in the next 20 years.**
- **By 2025, nanotechnology therapies (nano meaning extremely small) should be in use. Microscopic devices will monitor internal processes or destroy cancer cells before they can become a tumor.**

Source: *FUTURIST*, 2001.
U.S. News & World Report, 2001.

Who Will Be Able to Afford the Future?

It's 2025, and the so-called "Medicare meltdown" is in full swing. Arizona cannot afford to pick up the slack. As a result, health care is out of reach for most of the state's elders. More and more of the state's nearly 80,000 registered nurses and allied workers are leaving the field or moving to states with much more attractive recruitment, retraining and retention options.

To make matters worse, baby boomers failed to save enough to maintain an adequate standard of living over a long retirement. Doctors and prescriptions cost so much that only wealthy Arizonans can really afford them. Most elders simply do without. It's no wonder that resentments among the large, increasingly poor elder population pit the rich against everyone else.

John is a case in point. He worked in Arizona's semiconductor industry for 30 years. When John retired, he thought Medicare and his employer's supplemental plan would see him through his later years. Then, the worst happened. Medicare collapsed under the weight of increases in health care costs. The demands for long-term elder care and leadership paralyzed the State of Arizona, and John's savings evaporated in the ups and downs of the stock market. Now John cannot afford medications, health insurance or the hospital bills he has incurred.

Everyone knew this kind of thing could happen, but no one acted adequately to prevent it. The warning signs were in neon, especially by 2018, but leaders and consumers ignored the alarms. In fact, in 2020, voters turned down an initiative that would have paid for elder care. That is another reason why John and many of his peers are in trouble. Now, Arizona must face the consequences of its failure to act.

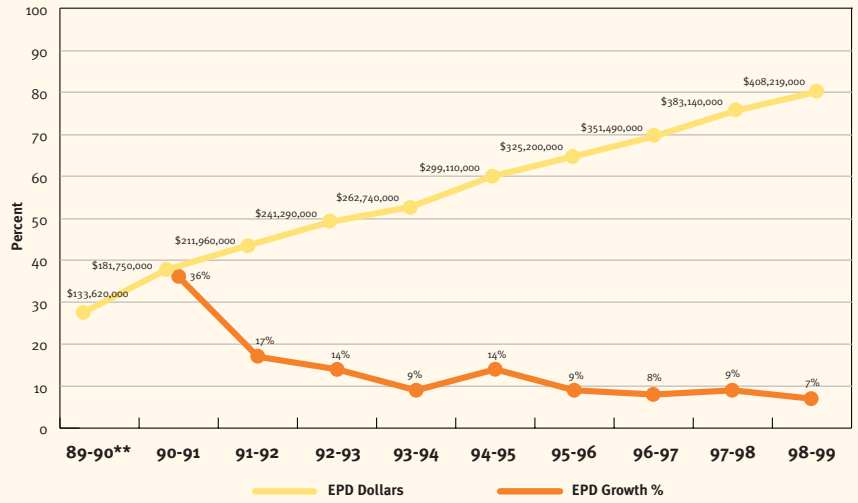
Age defines and divides Arizona's workforce. On one hand, young foreign immigrants fill most entry-level jobs in Flagstaff, Phoenix, Scottsdale, Tucson and the border cities; on the other hand, Arizona's elders also work in record numbers. Some politicians hail seventysomething workers as good for the state's economy, but others realize that elders have no choice. They must work to pay

Key Trends

- Negative economic factors converge, driving health care costs for elders beyond what most Arizonans can afford.
- Medicare cannot keep pace with change or demands.
- Older residents are forced to work longer.
- Debate over state tax policy is a stalemate.
- Health care for the aged becomes an intergenerational political issue.

Arizona's Long-term Care Costs for Low-Income Elderly and Physically Disabled Beneficiaries Are on an Upward Spiral.

State Spending for and Growth of Elderly and Physically Disabled (EPD) Long-term Care, Arizona Long-Term Care System, 1989-1999



* Elder beneficiaries account for roughly 60% and physically disabled 40%. The percentage of EPD growth shows the increase in beneficiaries between 1989 and 1999. The EPD dollars chart the state funds spent on elder and physically disabled beneficiaries between 1989 and 1999. The Arizona Long-Term Care System is part of the Arizona Health Care Cost Containment System.

Source: *Community Based Services and Settings Report,* Arizona Health Care Cost Containment System and Arizona Department of Economic Security.

the extraordinarily high health care premiums for the deductibles and coverage gaps that today's economic situation has forced upon the Medicare system. Even with Arizonans working longer, though, the Arizona Long-Term Care System (ALTCS) faces unprecedented demands. The eligibility criteria put into place in 2003 were never brought in line with economic and demographic realities. Now no one dares touch these entitlements.

AHCCCS absorbs fully 30 percent of Arizona's nearly $15 billion state budget with nearly half of that paying for long-term elder care. Federal payments used to offset the state's costs, but no more. The good news for some — but all too few — of Arizona's more than 360,000 octogenarians and other elders is that the perilous economic conditions have created "niche players" in health insurance. Most Arizona employers have helped this trend along by shifting from group health care to vouchers that individuals can use with any provider. To the extent they can afford it, some of the state's elder workers are finding high quality companies that match their preferences and needs. Still, workers now look at 75 as "retirement age," and less than half the state's elderly can afford any type of health insurance.

Amidst the ugly political wrangling between the elder "haves" and "have-nots," the Arizona Legislature accepts the "dependency ratio" explanation of today's reality. The ratio of working-age Arizonans to the state's kids and retirees is now the lowest in the state's history. Further, although the state's population over 65 increased by 133 percent in the past 25 years, the number of people contributing payroll taxes increased only 47 percent during the same period.

Arizonans pressure state leaders to lower and raise taxes at the same time. The argument for lower taxes is straightforward: give individuals more discretionary income so they can pay their health insurance premiums. The argument for raising taxes is equally compelling: create more public revenue so government can achieve economies of scale and make those payments instead. The lobbying at the state capitol is as contentious as anyone can remember. Elder advocates looking for help with health care go head to head with business proponents who want lower taxes. Meanwhile, Arizona's situation goes from bad to worse.

The astronomical costs of health care for the aged are the cause of deep-seated resentment both within Arizona's elder population and between segments of the state's age-divided workforce.

Projections for Health Care Expenditures for the Nation in 2010 Exceed $2.6 Trillion.

U.S. Health Expenditures, 2000 and 2010* (billions)

	2000	2010*
Total Private	$1,311	$2,637
Total Public**	$589	$117

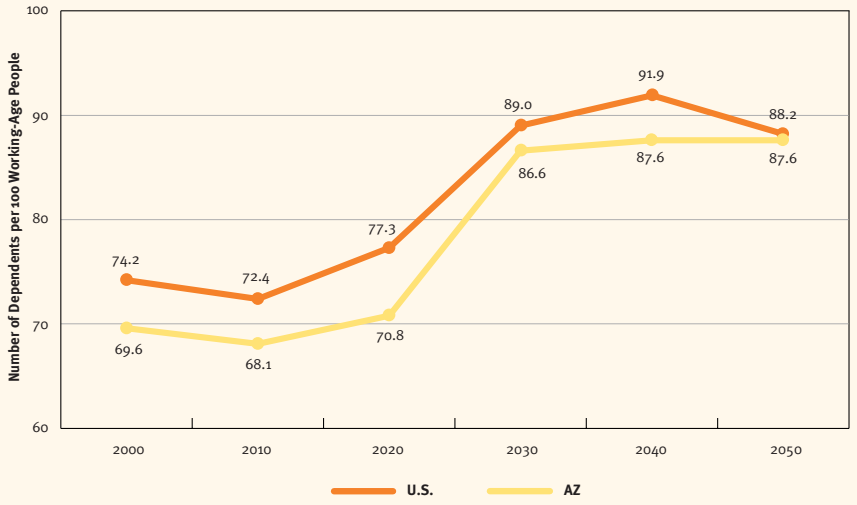
* Projected.

** Combination of federal, state, and local governments.

Source: National Health Expenditures Projections, Centers for Medicare and Medicaid.

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.

Arizona Takes Charge

In 2025, a mind-boggling array of issues has converged at a single point — health care for Arizona's elders. From businesses to families to politicians, most Arizonans feel this complex situation demands decisive, yet collaborative, action. More than ever, the respective problem-solving roles of government, the marketplace and the community are called into question.

Each of the issues that created the current health care challenge is clear in and of itself. Unfortunately, fitting the pieces together is one of the toughest tasks public, private and community leaders have ever faced.

Key Trends

- Changes in technology, economics and politics converge at the issue of elderly health care.
- Few can afford new medical technologies.
- Boomers are large in number, but politically fragmented.
- The role of government as problem solver is challenged.

"Miracle" drugs and other health care technologies seem to appear almost daily. Thousands of Arizona families from Nogales to Page and from Safford to Kingman now have hope for their elder loved ones where they previously had only despair. But such magic comes at a high price to cover the cost of research and development, and few people can afford it. Nonetheless, new methods can substantially prolong the lives of Arizona's more than 360,000 residents over 80 if they or their families or their employers or the state have the resources.

At the same time that health care technology is growing exponentially in pharmaceuticals, smart clothing and telecommunications, the health insurance industry is in chaos. Niche providers "cherry pick" the state's "best" clients — those Arizonans least likely to get sick and most able to pay high premiums. Arizona's other elders are mostly out of luck. Some observers refer to this situation as the flipside of the revolution in health care technology. Insurance companies routinely use sophisticated medical records to their advantage, as is their right under the Freedom of Medical Information Act of 2011.

Fortunately, Arizona's economy is flourishing, and state revenue is increasing at a steady pace. The private sector's new economy strategies and the recent growth in Arizona-based venture capital have worked to the state's benefit. In the past year, a record number of high-tech firms set up shop throughout Arizona to take advantage of the state's fabulous momentum. The best and brightest workers now compete hard for jobs here. Arizonans enjoy a quality of life that is undeniably good, maybe the best ever.

Success has its downsides though. With Arizona's population expanding by nearly five percent annually, the state and its communities are dangerously close to not being able to provide schools, roads and services fast enough to meet demand. Opposing political action groups complicate the situation. Ironically, baby boomers or their families fund both groups. One of these well-financed, politically savvy organizations wants state government to pay for elder health care. Boomers' kids, who want the best for their parents but also must cope with many demands for their time and money, lead this faction.

But every action has an equal and opposite reaction. Baby boomers who recall their 1960s values of sharing and concern for future generations view the situation differently. They seek to balance state funding for their health care with other important public programs such as education and land preservation. Arizona's political pundits are calling it a draw, since the boomer generation is clearly splintered.

Boomer-driven political forces, dramatic improvements in health technologies for elders, a robust state economy, out-of-sight health insurance costs — it's a strange brew. The best of times, the worst of times.

As happened in the early 1980s when the Arizona Legislature established AHCCCS (the Arizona Health Care Cost Containment System), crisis creates opportunity. Collectively, state and local officials, along with leaders from the private and nonprofit sectors, propose an umbrella under which collaborative actions can be taken to untangle these issues. The result is the Arizona Department of Elder Care Systems (DECS). But this resolution doesn't come easily considering Arizona's powerful tradition of not expanding government or increasing state bureaucracy.

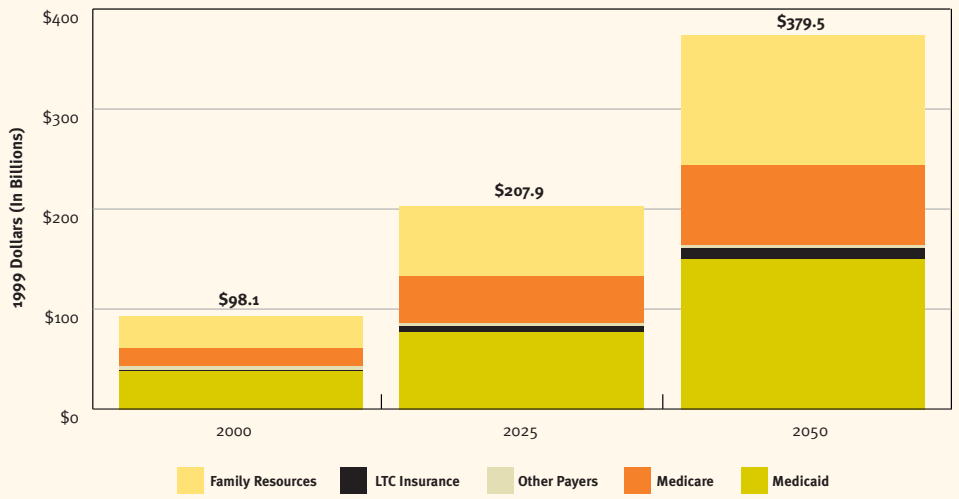
An appointed Board of Overseers with sweeping authority oversees DECS. Membership on the nine-person board is balanced among private sector, community-based and publicly elected leaders. They come from mid-sized communities in the Mogollon Rim territory, Verde Valley, Coconino Plateau, Cochise County and Yuma County as well as from the Phoenix-Tucson mega-lopolis. The DECS mission has two parts: 1) Keep Arizonans as healthy as possible; and 2) Develop, implement and oversee solutions to long-term health care problems. And, DECS has teeth. Other state agencies, as well as health insurance companies and local community care agencies, must answer to it.

It's no surprise that some people see DECS as an inappropriate government intrusion into the marketplace. Others, though, see it as a creative way of dealing with the confluence of elder care issues. Both sides agree on one thing — the new agency is fertile ground for proving that health care for the aged is best implemented at the local level; that our communities must, and do, have the capacity to care.

The nation will watch closely how well Arizona's new approach works. Others want to know if we have the compassion, collaboration and cash to serve and value our elders.

Substantial Family Resources Are Required for Long-term Care.

Long-term Care Costs, 2000-2050



Source: *The Long-term Care Financing Model*. The Lewin Group and U.S. Department of Health and Human Services, 2000.

Will Arizona's Communities be Good Places for Elders?

What grade would you give your community?

Health Care Accessibility and Cost:
A B C D F
Improvements Needed:_____
_____

Volunteer and Employment Opportunities:
A B C D F
Improvements Needed:_____
_____

Mobility — Pedestrian-Friendly, Easy Driving, Good Transit:
A B C D F
Improvements Needed:_____
_____

Community Support for Informal Care:
A B C D F
Improvements Needed:_____
_____

Cultural Activities and Libraries:
A B C D F
Improvements Needed:_____
_____

Lifelong Learning:
A B C D F
Improvements Needed:_____
_____

Housing:
A B C D F
Improvements Needed:_____
_____

Recreation:
A B C D F
Improvements Needed:_____
_____

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Research Report

The companion research report to the *Four Scenarios of Arizona's Future* was prepared by an interdisciplinary group of scholars and researchers from throughout Arizona. Dr. John Hall of the Arizona State University School of Public Affairs led the team. Their work, *The Coming of Age: Aging, Health and Arizona's Capacity to Care*, offers an easily read and understood analysis of the demographics that are shaping Arizona and the related health and community "systems" affecting the future. In addition, the report summarizes the results of a statewide survey of Arizonans ages 40-59.

The Coming of Age: Aging, Health, and Arizona's Capacity to Care is available at www.slhi.org

The report is organized around:

- The Coming of Age: Age Will Remake Society
- The Fundamental Facts: Arizona Cannot Escape Aging
- Mixed Messages About the Coming of Age from the Public and Professionals
- Aging Issues are Intricate Issues:
  - *Health Care Systems and Services for Arizona*
  - *People to Care for an Older Arizona*
  - *Healthy Aging for People and Communities*
- It's Time: Arizona Needs to Talk and Choose

The report supplies new information about the connection of Arizona's aging to health and health care, the workforce and community initiatives. *The Coming of Age* concludes with a call for dialogue about the choices Arizona's residents and leaders should consider and a possible five-point agenda for the state.

Morrison Institute for Public Policy

Morrison Institute for Public Policy conducts research that informs, advises, and assists Arizonans. A part of the School of Public Affairs (College of Public Programs) at Arizona State University, Morrison Institute is a bridge between the university and the community. Through a variety of publications and forums, Morrison Institute shares research results with and provides services to public officials, private sector leaders, and community members who shape public policy. A nonpartisan advisory board of leading Arizona business people, scholars, public officials, and public policy experts assists Morrison Institute with its work. A gift from Marvin and June Morrison of Gilbert, Arizona established Morrison Institute in 1981, and its work is now supported by private and public funds and contract research.

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School of Public Affairs

The School of Public Affairs is well known nationally. It's comprehensive programs include masters and doctoral studies, the Advanced Public Executive Program, and Morrison Institute for Public Policy. The School of Public Affairs' faculty, staff and students contribute frequently to research and service projects that benefit metropolitan Phoenix and Arizona. The School of Public Affairs also works hand in hand with the Urban Data Center at the ASU College of Extended Education.

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The purpose of *Arizona Health Futures* is to unravel an important health policy topic of relevance to Arizonans, provide a general summary of the critical issues, background information and different perspectives on approaches to the topic; tap into the expertise of informed citizens, and suggest strategies for action.

Our mission is to improve the health of people and their communities in Arizona, with an emphasis on underserved populations and building the capacity of communities to help themselves.

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ARIZONA**HEALTH**FUTURES

The Coming of Age

A Research Report on Aging, Health and Arizona's Capacity to Care

MAY 2002

St. Luke's Health Initiatives

The Coming of Age

Welcome to *The Coming of Age*

When a steamroller is coming down the road, you have three choices: Get out of the way, run to stay ahead of it, or lie down and get your clothes pressed.

The steamroller is age — old age — and it will remake our society in the first half of the 21st century. Everything from census numbers to personal experiences underscores the aging of our state and nation. The Coming of Age explores Arizona's capacity to handle this soon-to-be "gerontocracy" in positive ways.

Aging affects all dimensions of our society, but none so much as health care. Thus, St. Luke's Health Initiatives (SLHI) decided to dedicate part of its *Arizona Health Futures* program to exploring Arizona's capacity to meet the health care demands of an aging population. SLHI asked the Arizona State University School of Public Affairs and Morrison Institute for Public Policy to collaborate on The Coming of Age to inform Arizona's policy leaders and residents about these critical issues.

The Coming of Age engaged demographers, economists, public policy analysts, human service and medical professionals and citizens. Through its research, the team developed a realistic picture of Arizona's "capacity to care" for an elder population. The results of the research and the policy choices suggested by the findings are presented in this publication.

A companion piece, *The Coming of Age: Four Scenarios of Arizona's Future*, offers possible futures for the state that are based on the research. (See **www.slhi.org** or **www.morrisoninstitute.org**.) Other project products, available on these web sites, include team members' technical papers, an interdisciplinary reference guide and results of the project's public opinion research.

We hope that *The Coming of Age* sparks discussion among family members and in businesses and organizations as well as city halls and the legislature. Given the best thinking of all Arizonans, new ideas will emerge on how we can — and must — prepare for an older population. Whether or not today's information age gives way to the "age of wisdom," where longer lives mean better lives for individuals and a higher quality of life for everyone, may depend on those discussions and our decisions.

Roger Hughes, Ph.D.
Executive Director
St. Luke's Health Initiatives

John Stuart Hall, Ph.D.
Project Director
Professor, School of Public Affairs
Arizona State University

Rx
PATIENT NAME: Arizona Senior
DATE: January 2013
GENERIC NAME: Health care for increasing numbers of elderly citizens.
DOSAGE: As much as you can afford, or until you just can't take it anymore.
INDICATIONS: To be used after a period of low personal savings in combination with increased health care costs.
HOW TO USE THIS MEDICATION: After a reduction in public health insurance coverage, extensive research will result in limited options. Then, work well beyond retirement age to afford rising premiums – if you can get coverage at all.
POSSIBLE SIDE-EFFECTS: Strained family relations, shortage of cash. Frequent headaches are normal. If symptoms persist, contact your local government.
DATE OF EXPIRATION: Upon the collapse of strained state budgets.
CAUTIONS: If problems persist, nurses and other health care professionals may not be available to assist you.
KEEP OUT OF REACH OF LEGISLATURE!!

The Coming of Age

Project Director **John Stuart Hall**
Professor, School of Public Affairs, Arizona State University

A Research Report on Aging, Health and Arizona's Capacity to Care

MAY 2002

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Special acknowledgment is due to Roger Hughes and Jill Rissi for their intellectual contributions and insights into Arizona's future.

St. Luke's Health Initiatives
A Catalyst for Community Health

ARIZONA**HEALTH**FUTURES

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The Coming of Age Talking Points

Everyone ages. Each generation gives way to the next.

What's different today is that the next group of elders, namely the members of baby boom, is bigger than any other before it. The Coming of Age is one of the first projects in Arizona to look at the many issues presented by aging and our state and the community capacity to care for an older population.

Preparing for what will be dramatic changes calls for more than just cleaning our rose-colored glasses. The data and analyses in *The Coming of Age* are intended to help Arizonans and their leaders to understand the issues and the consequences of action and inaction.

The following points highlight the results of The Coming of Age research and some of their implications for Arizona.

The Coming of Age: Age Will Remake Society

- Approximately one in four Arizonans is a baby boomer. The eldest boomers will turn 62 in just 6 years (read eligible for Social Security) and be 70 years old in less than 15 years. By 2031 every baby boomer is over 65, and the oldest are 85.
- With longer and longer life spans, it is no wonder that the number of those 85 years old or more increased 82 percent between 1990 and 2000 and represent Arizona's fastest growing age group. More and more of the "oldest old" will mean mushrooming costs for elder care.
- Baby boomers have half as many children to depend on in old age as today's seniors. Are Arizona's communities ready for a new wave of elders? Where will help come from if family members are few, while Social Security and Medicare are strained or drained by the size of the boomer generation?
- The good news is that technology offers new options for better health. The bad news is that increasing health care costs may widen the gap between Arizona's "haves" and "have nots."
- Arizona's public, private and personal capacity to care for more elders is just beginning to be explored. As age-related needs for care increase, capacity to care may be at risk.

The Fundamental Facts: Arizona Cannot Escape Aging

- Arizona's 60+ population will triple in size from approximately 875,000 today to just under 3 million by 2050.
- In 2000, the over-60 set accounted for 17 percent of the state's population. Look for 24 percent in 2020 and 26 percent in 2050.
- The Arizonans over 65 years of age will be roughly comparable to the number of children under 17 in less than 30 years. Fewer and fewer Arizona workers will pay taxes to support the young and the old.

Mixed Messages About The Coming of Age from Professionals and the Public

- Professionals in aging fields voiced concern that inadequate attention from top leaders, besides insufficient dollars and fragmented programs, has put Arizona on a collision course with aging.
- In a statewide survey of Arizonans 40-59 years old for The Coming of Age, only 18 percent said the aging of the population was a serious problem for the state, but it does present some personal anxieties to three out of four of those interviewed.

- Approximately 75 percent of those surveyed voiced some concern about their ability to care for an elder parent or relative, and 70 percent feared for their own financial futures. Arizonans with low incomes today expected to be the "have nots" of tomorrow.
- One-third of those in the survey cares for an elder now, and families are the most important source of care. Government (federal first, then state and local) has a part to play too, especially for those who are poor. Medicare, unfortunately, was seen as "iffy" for baby boomers. Many Arizonans worry that public programs for elders are of dubious quality.
- Despite concerns, 79 percent of the baby boomers surveyed felt optimistic about getting older.

Aging Issues are Intricate Issues

Health Care Systems and Services for Arizona

- 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.

People to Care for an Older Arizona

- 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.

Healthy Aging for People and Communities

- 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.

It's Time: Arizona Needs to Talk and Choose

Arizona needs to gather round and discuss the issues and choices of aging.
The big issues on the table should be:

- Leadership
- Infrastructure
- Dedicated funding
- Elder independence
- Individual financial preparation

Arizona's communities should prepare now by building their capacity to be elder friendly.

Successful aging means the ability to maintain three key behaviors or characteristics:

- Low risk of disease
- High mental and physical function
- Active engagement with life

Successful Aging:
The MacArthur Foundation Study.

Capacity means the public, private, community and personal resources that could be brought to bear on an issue or situation and the interrelationships among them.

Picture Yourself: Understanding an Aging Arizona

Picture yourself today with 99 other Arizonans. Together you comprise a group that is representative of Arizona's age. Now, fast forward to 2030. Age rules.

Less than 5 years old:

Today:
2030:

Roughly of school age (5-19):

Today:
2030:

Either starting careers or in the prime of their working lives (20-59):

Today:
2030:

60+ years of age:

Today:
2030:

Source: Arizona Department of Economic Security.

The Coming of Age: Age Will Remake Society

Aging: If It's Not Your Issue Now...It Will Be.[1]
This bit of bumper-sticker wisdom makes a good point.
Everyone ages. Each generation gives way to the next.

What's different today is that the next group of elders, namely the members of baby boom, is bigger than any other before it. Every state in the nation is anticipating the aging of its population. The Coming of Age is one of the first projects in Arizona to look at the many issues presented by aging and our state and community capacity to care for an older population.

The Coming of Age is about today — The experiences among approximately 875,000 Arizonans who are over age 60 now and what 1.24 million middle-aged residents think about getting older.

The Coming of Age is also about tomorrow — What will it mean for our state, in about 2020, when every fourth person you meet on the street is 60 years old or more? What about when roughly the same number of Arizonans are over age 65 as are under 17?

The issues are complex, even intricate. Choices have to be made that will affect nearly everyone's quality of life. Preparing for these dramatic changes calls for more than just cleaning our rose-colored glasses. The data and analyses in *The Coming of Age* are intended to help Arizonans and their leaders to understand the issues and the consequences of action and inaction.

Boomers Join a Complex Ensemble
As the 77 million members of the baby boom (born from 1946–1964) have moved through each life stage, they have remade U.S. institutions and expectations. Higher education mushroomed as baby boomers went to college. They expanded the labor force as millions of women began to work outside the home. They brought new energy to the arts and community organizations. They spawned innovation after innovation and trend after trend. Today, baby boomers are the nation's most visible leaders in nearly every field. With the 20th century's largest generation reaching retirement age around 2008, "elderhood" is their next stop.

However, unlike their domination of schools for example, baby boomers as elders will share the spotlight with others. They are now part of a complex ensemble in which many types and ages of people play substantial roles. What's more, boomers themselves are diverse and nowhere near unanimous about their desires.

Arizona's 60+ population will triple in size by 2050 and constitute more than a quarter of all residents. The number of persons over age 60 in Arizona will grow from approximately 875,000 in 2000 (about 17%) to 1.8 million in 2020 (24%) to almost 3 million (26%) in 2050.[2] Between 2000 and 2025, Arizona will rank ninth nationally in the growth of the 65+ population.[3] There are many things about the next 20 years that cannot yet be discerned, but significant change in the age structure of our state and nation is a given. We now must strive to understand the major societal process of the first half of the 21st century: the coming of age.

Today's 40-year-old is tomorrow's 60-year-old.
In Arizona, the next generation of elders is big enough to color the state gray.

TALKING POINTS

- **Approximately one in four Arizonans is a baby boomer. The eldest boomers will turn 62 in just 6 years (read eligible for Social Security) and be 70 years old in less than 15 years. By 2031 every baby boomer is over 65, and the oldest are 85.**
- **With longer and longer life spans, it is no wonder that the number of those 85 years old or more increased 82 percent between 1990 and 2000 and represent Arizona's fastest growing age group. More and more of the "oldest old" will mean mushrooming costs for elder care.**
- **Baby boomers have half as many children to depend on in old age as today's seniors. Are Arizona's communities ready for a new wave of elders? Where will help come from if family members are few, while Social Security and Medicare are strained or drained by the size of the boomer generation?**
- **The good news is that technology offers new options for better health. The bad news is that increasing health care costs may widen the gap between Arizona's "haves" and "have nots."**
- **Arizona's public, private and personal capacity to care for more elders is just beginning to be explored. As age-related needs for care increase, capacity to care may be at risk.**

Long Lives Are a Reality

U.S. Life Expectancy, 1900 and 1997

In 1900, an American could expect to live for an average of 49 years.

In 1997, the average life span was 77 years.

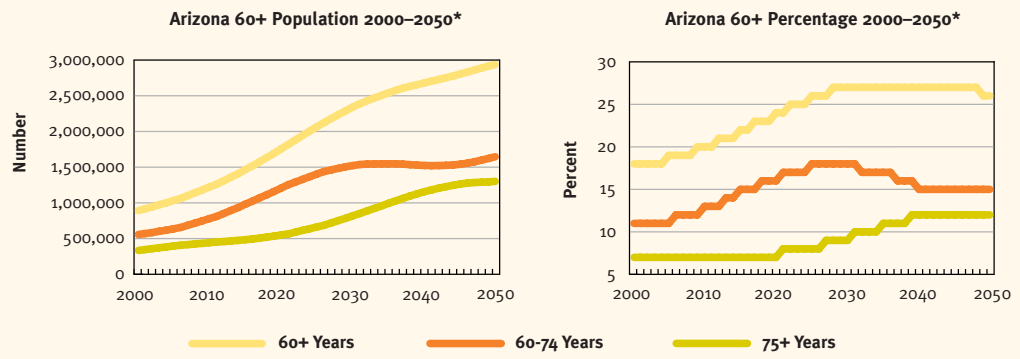
Women live longer than men. At age 65, in 1997, women could expect another 19 years of life and men an additional 16 years.

At age 85, women have an average of 7 years of life, while men have about 6.

Long lives are now the rule, rather than the exception.

Source: National Vital Statistics System.

Figure 1: Arizona's 60+ Population Will Increase Notably for the Foreseeable Future.

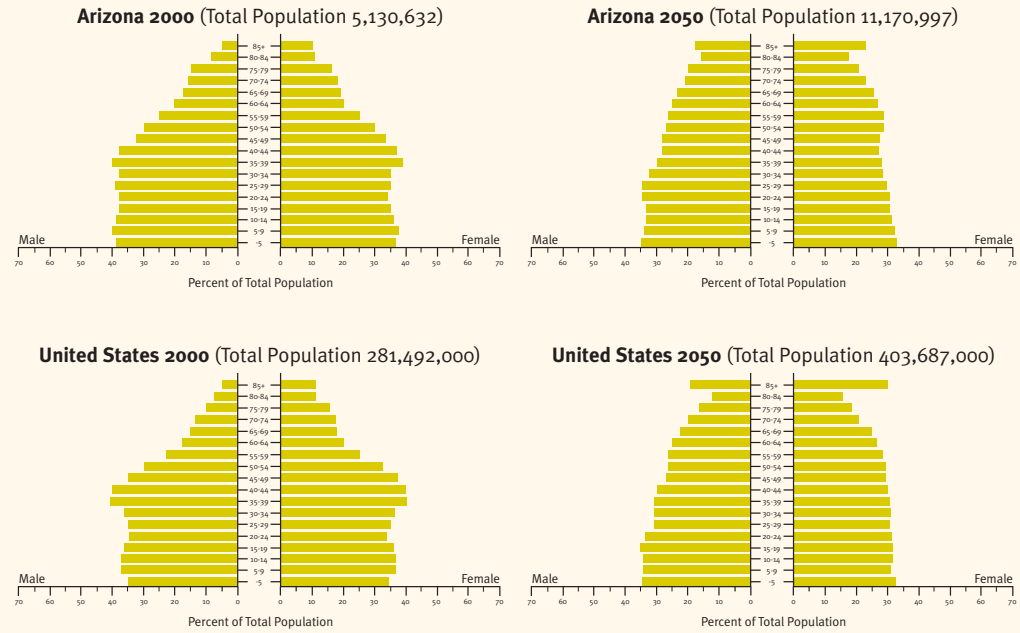


* Projected.

Source: *Geo-demographics of Aging in Arizona*, 2001.

Figure 2: Good-bye Pyramids. Hello Blocks.

Arizona and United States Male and Female Population by Age, 2000 and 2050



Source: U.S. Census Bureau.

When choosing images or models, remember that everyone sees himself as 10 to 15 years younger than his true age.

Joanna L. Krotz, Microsoft bCentral.

Still Ambivalent About Old Age

"We are bombarded with contradictory information about what it means to grow old. News reports of people living longer than ever are juxtaposed with horror stories of life in nursing homes and elders wishing for death. Inspiring anecdotes of energetic 85-year-old marathon runners or CEOs or composers who seem as young as ever are followed on the nightly news by stories on the barrenness of life in gated retirement communities filled with decrepit old people who feel superfluous."[4]

Scholars, pundits and poets have considered whether the aging glass is half full or half empty for centuries. Robert Browning's positive perspective, "Grow old with me! The best is yet to be." contrasts with Shakespeare's contention that old age "is second childishness and mere oblivion, sans teeth, sans eyes, sans everything."[5] Novelist Tom Wolfe goes to the heart of a contemporary view, "In the late nineteenth and early twentieth centuries, old people in America had prayed, 'Please God, don't let me look poor.' In the year 2000 they prayed, 'Please, God, don't let me look old.'"[6]

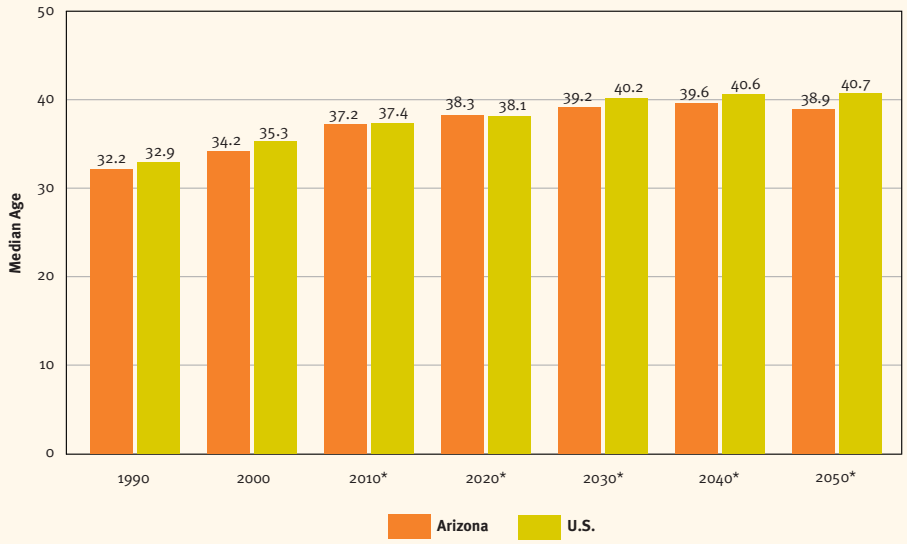
In Arizona, the push and pull of attitudes about aging is just as prevalent. Complaints about "snowbird" drivers appear as often as heartwarming stories about Green Valley volunteers. Among Arizonans who participated in research for The Coming of Age, the image and experience of old age have improved markedly. Simply put, life today is not as hard as it used to be, so later years can be more enjoyable and productive. However, many of these same people acknowledged their fears of old age.

Acknowledging Demographic Destiny

The facts are clear: Arizona will be home to a significantly larger number of people within the near future, and this population will be older than it is today. What is unclear is whether Arizona's people and institutions are ready for the new demographics. The Coming of Age provides a window through which to view this "capacity" question. What is the tug and pull of supply and demand? Can the societal fabric of public and private institutions, professional organizations, faith-based and community and family arrangements stretch across the growing needs? Do we have the will to invest our resources wisely?

Figure 3: Soon, Arizona's Median Age Will Be Nearly 40 Years Old.

Arizona and United States Median Ages 1990–2050*



* Projected.

Source: U.S. Census Bureau, *Age 2000*, September 2001. U.S. Census Bureau National Population Projections. Arizona Department of Economic Security Population Projections.

The facts are clear: Arizona will be home to a significantly larger number of people within the near future, and this population will be older than it is today.

Such dramatic changes as are projected for Arizona are bound to have multiple, interactive consequences. Numerous studies acknowledge the positive and negative effects of population growth. Relatively few, however, look at the systemic public policy consequences of growth combined with aging. What will the social, economic and political impacts of this "double whammy" be? What plans and investments need to be made to face the future realistically? These questions defy easy answers. What seems remarkable is the relative absence of study of, and efforts to prepare for, this change.

Or, is the apparent lack of attention unremarkable given what we know about human behavior and public policy? *You Can't Enlarge the Pie*, a recent book about the forces that often distort public decision-making, explains the tendency of residents and their elected representatives to "live for the moment," and engage in "wishful thinking." Authors detail how short-term outlooks result in "discounting the future."[7]

Capacity means the public, private, community and personal resources that could be brought to bear on an issue or situation and the interrelationships among them.

Some Arizona public policy veterans might explain the seeming disinterest in the coming "age wave" as consistent with Arizona's traditional outlook on economic growth. To these observers, substantial, sustained growth of the retirement-age population is a blessing. Still other spectators contend that the 1990s state tax cuts, competition for public funds and today's chancy health care economics reduce capacity to provide services to the state's elders when rising demands are obvious. Recent HMO actions limiting prescription drugs or dropping coverage entirely for many of Arizona's rural seniors (some of whom recently moved to small towns to enjoy their version of the good life) exemplify the problems that will only worsen with time. On one hand, there is continuing confidence in the power of market solutions: "the graying of America...is a guaranteed opportunity for someone."[8] On the other is a "capacity crisis" in health and care.

The certainty and size of the age issue suggest that policy makers and the public need to look at this 21st century process differently. Demographics are destiny, and Arizona's future well-being is at stake.

Aging in the Arizona Context

Because of the global certainty of aging, every industrialized nation grapples with similar challenges and the growing demand for health and care services.[9] The issues take on special meaning in Arizona in part because the state has experience with elder in-migration and is expected, to some extent, to continue to be an attractive retirement destination.

The demographic shift to an older population will filter through all of the state's systems, ranging from the economy to the making of public policy. The effects will show up not just in health care services, but also in education and training, patterns of advocacy and the behavior of families and communities around elder care.

The demographic shift to an older population will filter through all of the state's systems, ranging from the economy to the making of public policy. The effects will show up not just in health care services, but also in education and training, patterns of advocacy and the behavior of families and communities around elder care. Predictably, self-interest will rule the day. But it need not carry the day. The state will need all of the arts of effective communication and collaboration if it is to succeed in managing this shift.

It is not, however, as if no one in Arizona has ever thought about aging. Thousands of experts, planners and advocates spend their professional and personal time studying the issues, helping individuals and planning for the state. The Governor's Advisory Council on Aging, the Arizona Long-Term Care System (a part of the state's Arizona Health Care Cost Containment System), the Arizona Department of Economic Security's Aging and Adult Administration and its Home and Community-Based Care Initiative, the Arizona Department of Health Services' Healthy Arizona 2010 effort and many other programs, the legislature's Long-term Care Coordinating Committee, the Attorney General's Senior Service Center, the Pima Council on Aging's Commission on the Future, the Arizona Center on Aging at the University of Arizona and the Maricopa Association of Government's Elder Mobility Task Force are just some of the many significant efforts underway to serve and anticipate the needs of today's and tomorrow's elders. Arizona also counts numerous nonprofit organizations and educational institutions among its resources, from the Alzheimer's Association to the Gerontology Association to Yavapai College's Center on Aging.

The health care industry in Arizona includes such world-renowned facilities as Barrows Neurological Center and Mayo Clinic. Expansions of full-service hospitals and regional medical centers are underway in Prescott, Flagstaff and Safford. Arizona can draw on approximately:

- 1,200 licensed assisted living facilities
- 91 home health care agencies
- 143 nursing homes
- 61 hospitals
- Over 11,000 practicing doctors
- More than 33,000 nurses with approximately one more licensed practical nurse or certified nursing assistant for every registered nurse

In addition, Arizona residents are not afraid to act on issues of great concern to the state. Voters' choices have marked large portions of the Arizona state budget for specific purposes. In recent statewide elections, for example, state voters approved a sales tax increase for education, a plan to increase health care coverage for the working poor and a system for "clean elections." The effects of voter-approved "growing smarter" requirements are beginning to be seen in local planning as are recent transit levies.

Clearly, Arizona has public, private, community and individual capacity. The question is whether Arizona has enough of, and the best mix of, the right stuff. The programs and organizations in place today developed when the state's population was younger than the nation's, and elders were viewed as just another interest group or market segment.

Now "the times, they are a-changin'...."

Facing the Big Issue

The devilishly complex topics of aging, health and capacity called for multidisciplinary, multi-method research. Studying just aging, or health, or community capacity would not be enough. This is a "systems" problem. Thus, this research starts at the intersection of the rough-and-tumble business of health care and of community capacity, lifestyle incentives and public decisions about resources.

To better understand this "systems problem," an interdisciplinary team of scholars from Arizona State University, the University of Arizona, and other universities and consulting firms conducted interviews and other research on demographics, economics, public policy, aging and health. The Coming of Age also conducted in-depth discussions with professionals and the public throughout Arizona as well as a statewide, representative public opinion survey of those who are now between 40 and 59 years of age. In addition, The Coming of Age created *Four Scenarios of Arizona's Future*, describing plausible futures for the state and consequences of various choices.

The report is organized around:

- The Fundamental Facts: Arizona Cannot Escape Aging
- Mixed Messages About the Coming of Age from the Public and Professionals
- Aging Issues are Intricate Issues:
  - *Health Care Systems and Services for Arizona*
  - *People to Care for an Older Arizona*
  - *Healthy Aging for People and Communities*
- It's Time: Arizona Needs to Talk and Choose

The ideas, facts and choices will help leaders and residents to come to grips with the choices inherent in the coming of age.

Life expectancy at the time of the Roman Empire was about twenty-eight years...from the birth of Christ to 1900, each year of history saw an average gain of three days in life expectancy.

Each year since 1900, however, has seen a gain of 110 days in average life expectancy.

Successful Aging:
The MacArthur Foundation Study.

Clearly, Arizona has public, private, community and individual capacity. The question is whether Arizona has enough of, and the best mix of, the right stuff. The programs and organizations in place today developed when elders were viewed as just another interest group or market segment.

The Fundamental Facts: Arizona Cannot Escape Aging

Where aging is concerned, numbers tell some interesting stories. The best place to start to understand Arizona's choices about the future is with the fundamental facts.

Table 1: Generational Players in The Coming of Age

Generation	Years	Age
Swing Generation	1911–1926	76–85+
Silent Generation	1927–1945	57–75
Baby Boom	1946–1964	38–56
Generation X	1965–1979	23–37
Millennium Generation	1979–2001	1-23

Source: *Young v. Old: Generational Combat in the 21st Century*. Harris Interactive.

Source of Demand: Arizona's Population Surges

In recent decades, Arizonans have become accustomed to "fastest-growing" labels. Between 1990 and 2000, the state again recorded considerable gains in population. However, notable changes in certain age and ethnic groups also took place. For example, the number of those 85 years old and over expanded more rapidly than any other age group. In 2000, the Hispanic population increased to the point where Hispanics now account for more than 25 percent of Arizona's population.

Table 2: Between 1990 and 2000, Arizona's Population Expanded by 40 Percent; The Number of 85+ Residents Increased Faster Than Other Groups.

Arizona Population by Age, 1990 and 2000

Age	Arizona 1990	Arizona 2000	% Change
All Ages	3,665,228	5,130,632	40%
60+	631,648	871,536	38%
85+	37,717	68,525	82%

Source: *Geo-demographics of Aging in Arizona*, 2001. Arizona Department of Economic Security.

Table 3: All Age Groups Increased Faster in Arizona Than in the Nation.

Population Ages 18–34, 35–64, and 65+ in Arizona and United States, 1990 and 2000

	Total 1990	Total 2000	% Change
AZ	3,665,228	5,130,632	40%
U.S.	248,709,873	281,421,906	13%
	18–34 1990	**18–34 2000**	**% Change**
AZ	1,027,579	1,256,766	22%
U.S.	69,913,698	67,035,178	-4%
	35–64 1990	**35–64 2000**	**% Change**
AZ	1,177,756	1,839,080	56%
U.S.	83,949,912	107,101,163	28%
	65+ 1990	**65+ 2000**	**% Change**
AZ	478,774	667,839	40%
U.S.	31,241,831	34,991,753	12%

Source: *State Data Center Newsletter*, Arizona Department of Economic Security, Summer 2001.

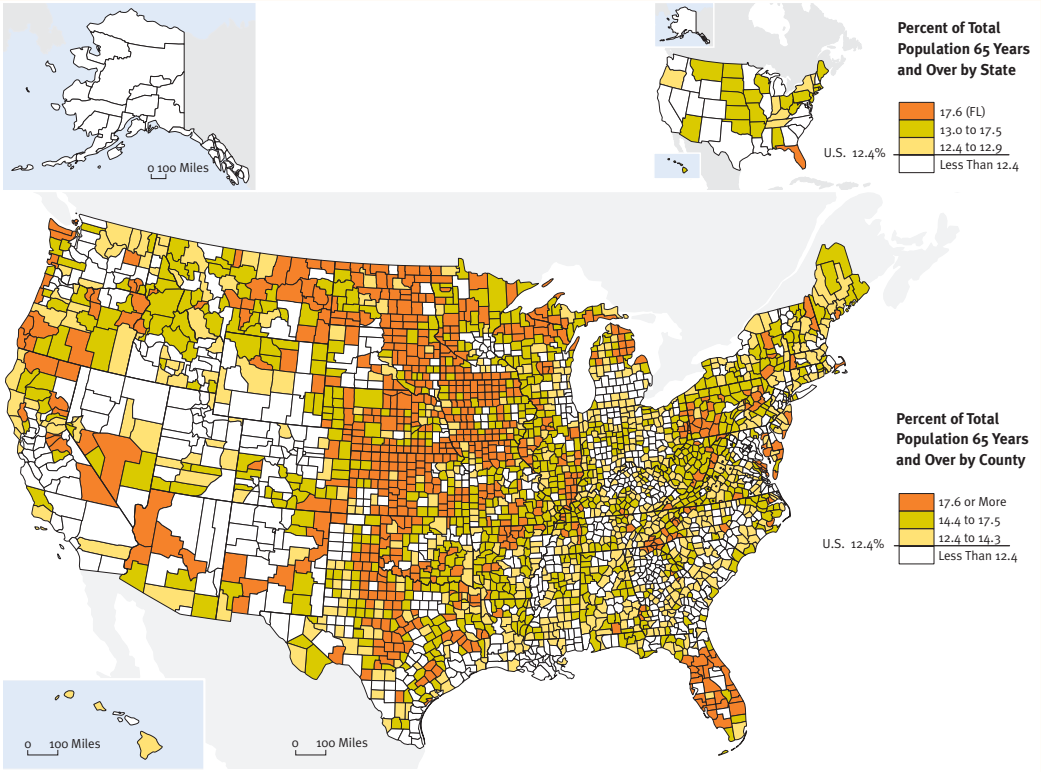
TALKING POINTS

- **Arizona's 60+ population will triple in size from approximately 875,000 today to just under 3 million by 2050.**
- **In 2000, the over-60 set accounted for 17 percent of the state's population. Look for 24 percent in 2020 and 26 percent in 2050.**
- **The Arizonans over 65 years of age will be roughly comparable to the number of children under 17 in less than 30 years. Fewer and fewer Arizona workers will pay taxes to support the young and the old.**

Despite its population gains, among states in 2000, Arizona, with 13 percent, missed the "top ten" in proportion of elders 65 years old or more. Florida ranks number one in elder population.

Figure 4: The Coming of Age is Not Unique to Arizona. Many States Are Looking to a Gray Future.

Percent 65 Years and Older, 2000



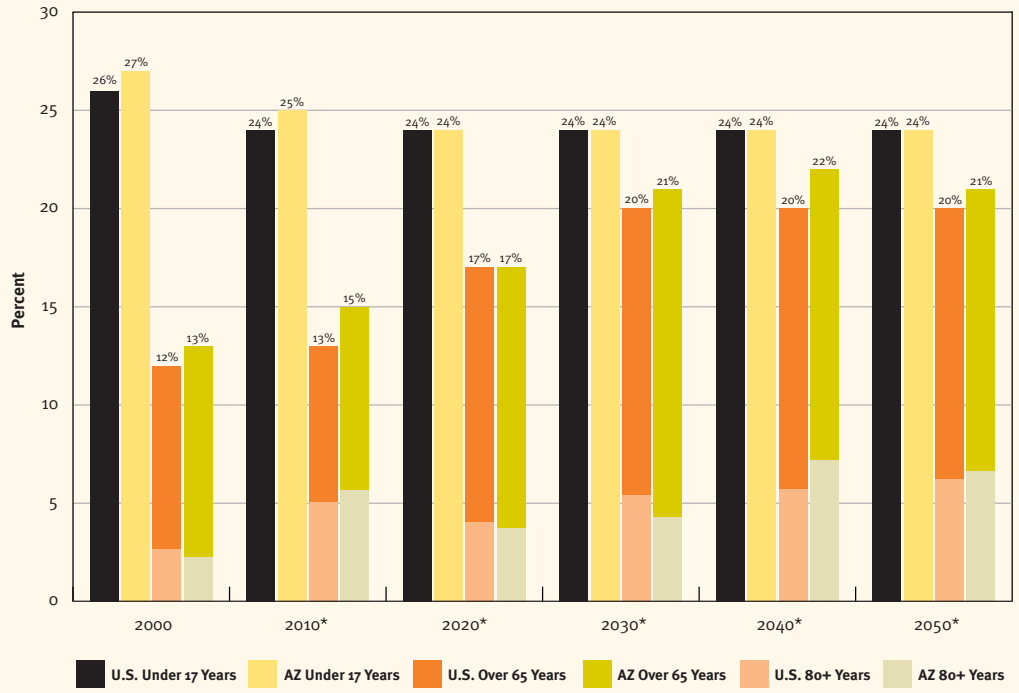
Source: *The 65 Years and Over Population: 2000*, October 2001, U.S. Census Bureau.

No End in Sight

Births, deaths and migration determine population growth. For years, Arizona has attracted young workers and families from throughout the United States and from Mexico and other countries, as well as older people looking to retire. More in-migration and foreign immigration, high birth rates among some population groups and increasing life expectancies will continue to push Arizona's population up. As a result, Arizona's total population may top 6 million by 2010, 7 million by 2020 and 8 million by 2030. Arizona differs from other aging states because it can also look forward to more young residents, as well as elder ones.

Figure 5: By 2030, the Elder Population Will Be Roughly Comparable to Children Under 17. The Over-80 Portion Will Get Bigger and Bigger.

Age-Specific Populations Arizona and United States, 2000–2050*



* Projected.

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

Where Arizonans Live

Arizonans reside primarily in Maricopa and Pima counties, and 80 percent of the growth in the older population between 2000 and 2050 is expected to occur in these urban counties.[10] However, other areas — notably Mohave, Yavapai, LaPaz and Gila counties — today include a greater proportion of elder residents than Maricopa and Pima. Yavapai, Gila and Yuma counties, in particular, have courted retirees as an economic development strategy.

Table 4: Arizona's Most Rural Counties Have the Highest Proportion of Residents Over Age 65 Now, Plus Many Residents Under 18.

Arizona Counties' Population by Age, 2000

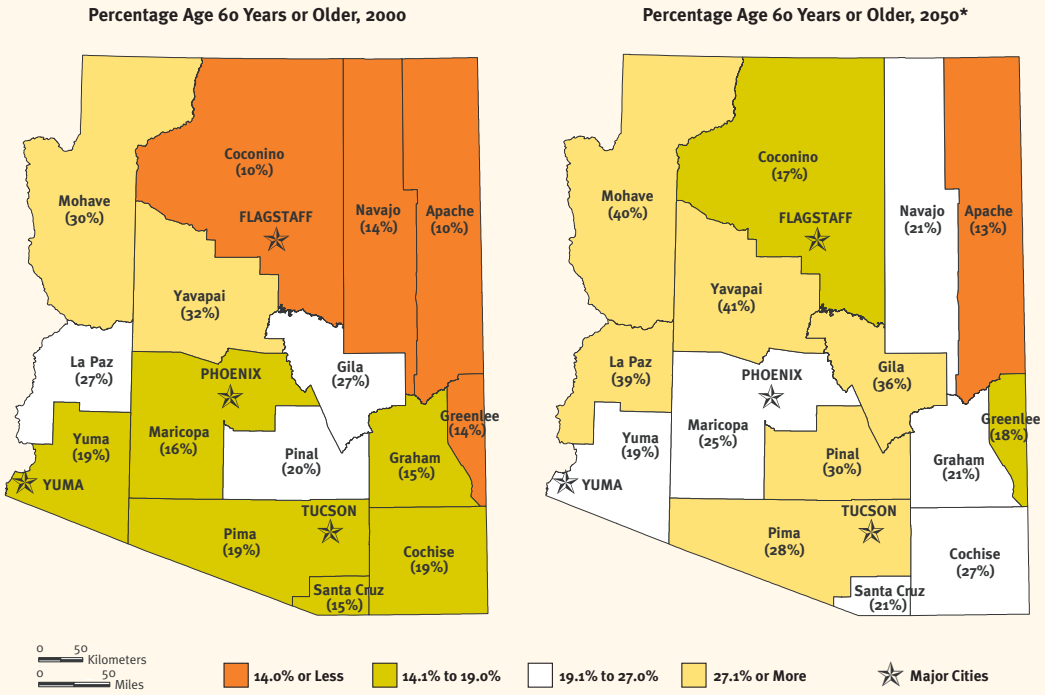
Area	2000 Population	<18%	18–24%	25–34%	35–44%	45–54%	55–64%	65+%
Urban* Maricopa and Pima	3,915,895	26.5	10.3	15.4	15.4	12.2	8.0	12.2
Rural-Urban** Coconino Yuma	276,346	28.8	11.9	13.2	14.0	11.4	8.2	12.5
Rural-Rural*** Apache, Cochise, Gila, Graham, Greenlee, La Paz, Mohave, Navajo, Pinal, Santa Cruz, Yavapai	938,391	26.5	8.1	11.1	13.7	12.8	11.2	16.6
Arizona	5,130,632	26.6	10.0	14.5	15.0	12.2	8.6	13.1

* Counties with a metropolitan population exceeding 500,000. ** Counties with large rural areas but containing metropolitan areas with populations of 50,000 or more. *** Counties with less metropolitan population.

Source: *Assessment of Arizona Health Care Coverage Report*, Southwest Border Rural Health Research Center, University of Arizona, November 2001.

Figure 6: Urban Counties Will Be Home to Most, but Rural Counties Will Have Their Share of Elder Growth.

Arizona Elder Population by County, 2000 and 2050*



* Projected.

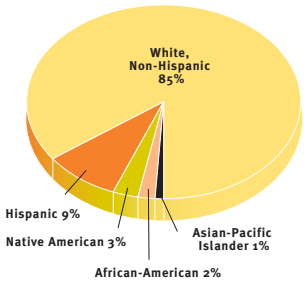
Source: Arizona Department of Economic Security. Maps created by IT Research Support Lab – GIS Services, Arizona State University, Summer 2001.

Diversity and Age in Arizona and United States

Tomorrow's aged Arizonans will exhibit similarities and differences when compared with those of today. For example, women will continue to dominate the ranks of the over-65. Though white residents are today's aged, tomorrow's elders will be more diverse in heritage, health needs and outlooks.

Nationally, the number of Hispanic elders grew 67 percent between 1990–2000 compared to 9 percent among the non-Hispanic white elderly. With greater diversity and rapid growth in the United States and Arizona, the aged of the future will include more Hispanics in particular.

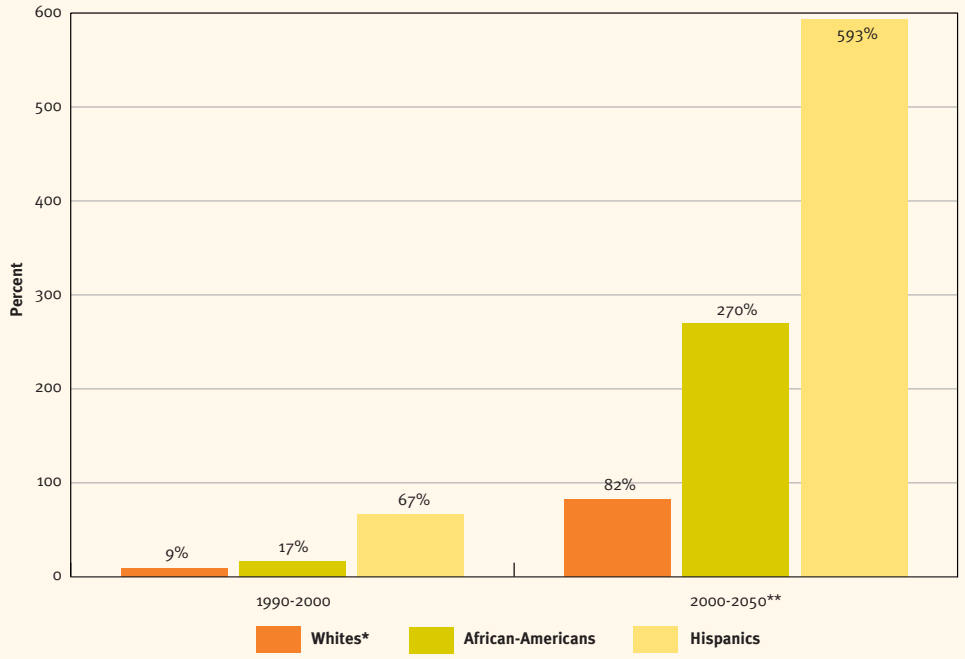
Figure 7: Whites Dominate Arizona's 60+ Group Now.



Source: U.S. Census Bureau Estimates, 1999.

Figure 8: Growth Among African-American and Hispanic Elders Will Far Outpace Other Groups in the Next 50 Years.

Elder Growth in United States, 2000–2050**



* Non-Hispanic. ** Projected.

Source: U.S. Census Bureau National Population Projections.

Age Patterns Differ from Community to Community

Newcomers to Arizona have been a major force behind the state's growing population, and elders constitute an important component of the mix of in-migrants. But the patterns of in- and out-migration may be surprising. According to Arizona State University geographer Patricia Gober, moving peaks when people are in their 20s and declines until individuals reach retirement age. Then, a "meaningful minority" chooses to go to a new place. In Arizona, estimates show that nearly half of the state's retirement-age residents "moved here after turning 55 years of age."[11]

For Arizona, the traditional moving patterns "mean that the vast majority of our new residents are working-age adults with their school-age children. Although these groups are likely to move to the state, they are also prone to move out when economic and personal circumstances dictate. Elderly, on the other hand, comprise a relatively small proportion of all in-migrants, but they tend to stay put once they arrive. It is straightforward to assume, given the extremely low migration rates of middle-aged people, that the vast majority of 50-year-old Arizonans will age in place and constitute the new crop of 60-year-olds in 2010."[12]

Table 5: Today, Sun City is the State's Oldest Community; Gilbert is the Youngest.

Population, Median Age and 60+ Population in Selected Communities, 2000 Ranked by % of 60+

Community	Median Age	Total Population	60+Population	60+%
Sun City West	73.2	26,344	24,318	92
Sun City	75.0	38,309	34,086	89
Green Valley	72.2	17,283	14,486	84
Sun Lakes	69.3	11,936	9,592	80
Youngtown	65.3	3,010	1,746	65
Carefree	55.2	2,927	1,139	39
Payson	48.9	13,620	4,934	36
Wickenburg	48.4	5,082	1,792	35
Surprise	46.1	30,848	10,712	35
Prescott	47.8	33,938	1,344	33
Sedona	50.5	10,192	3,380	33
Tombstone	48.7	1,504	456	30
Oro Valley	45.3	29,700	8,608	29
Litchfield Park	44.7	3,810	1,061	28
Fountain Hills	46.4	20,235	5,329	26
Paradise Valley	46.3	13,664	3,173	23
Kingman	39.6	20,069	4,615	23
Tucson	32.1	486,699	73,884	15
Phoenix	30.7	1,321,045	145,232	11
Glendale	30.8	218,812	22,508	10
Tempe	28.8	158,625	15,730	10
El Mirage	24.6	7,609	699	9
Chandler	31.2	176,581	14,705	8
Flagstaff	26.8	52,894	4,153	8
Avondale	29.0	35,883	2,789	8
Gilbert	30.1	109,697	6,287	6

Source: *Geo-demographics of Aging in Arizona,* 2001.

Winter Visitors Still Make a Difference

Winter tourism contributes millions of dollars to the state's economy and for the winter season approximately 300,000 to its population. According to the Center for Business Research at Arizona State University, the largest concentration of "snowbirds" is in the Phoenix/Apache Junction area. Yuma, Tucson and La Paz, Mohave and Pinal counties also place as popular destinations.[13] Winter visitors tend to be "young-old married couples" in good health. Although winter visitors strain emergency care, "it is unlikely that snowbirds will significantly affect the demand for long-term chronic care because declining health usually brings an end to seasonal migration."[14] Like elder migration, questions abound on whether or not the state's historic winter visitation will continue at the same pace as in the past because of increased negatives such as traffic, overcrowding and air pollution.

Affluence and Employment Among Arizona's Elders

In 1999, the annual Social Security retirement benefit averaged approximately $9,800. In 2000, the national median household income for those below 65 totaled $48,770. For those over 65, median household income was $28,147.[15] Because of the high proportion of relatively young, affluent retiree migrants, Arizona's elders traditionally have been relatively well to do. The newcomers on

average, have been "younger, wealthier, more highly educated and most independent of all retirees."[16] For example, in Arizona 81 percent of householders age 65 and older owned their homes, compared to 77 percent nationally and just 59 percent of Arizona's younger households.[17] In addition, Current Population Survey data from 1998–2000 showed that nine percent of Arizona residents age 65+ live below the federal poverty level, as compared to ten percent nationally. This situation may change as more Arizonans age in place. Since Arizona has lagged the nation in almost all income measures, Arizona's future seniors may not be as affluent as those in the past.

Table 6: Arizona Still Falls Behind the Nation in Per Capita Income, Ranking 38, but Income from Dividends, Interest and Retirement is Slightly Higher.

Arizona and United States Per Capita Personal Income, 2000

Item	$ AZ Per capita	Ratio to U.S.
Per capita personal income	24,991	85%
Per capita retirement and other	2,930	88%
Per capita dividends, interest and rent	4,700	87%
Per capita dividends	1,229	91%
Per capita interest	3,081	87%
Per capita rent	390	78%

Source: U.S. Bureau of Economic Analysis.

Table 7: Few Arizonans Are Eligible for Both Medicare and Medicaid – Another Sign of Relative Affluence.

United States, Arizona and Top Ranking States for Dual Eligible Residents, 2000

Area	# Dual Eligible Beneficiaries	Rank
U.S.	**5,455,631**	**NA**
Arizona	**57,696**	**29**
California	821,488	1
New York	387,633	2
Texas	360,810	3
Florida	343,996	4
North Carolina	224,093	5

AHCCCS is Arizona's Medicaid program.

Source: www.statehealthfacts.kkf.org.

Employment among elders will be an important topic in the future. Survey after survey shows that today's middle-aged workers are talking about continuing to work as they reach traditional retirement ages. At this time, Arizona's total labor force participation (65%) is a bit below the national average (67%), but the percentage of seniors in the labor force matches that for the country (13%).

Arizona Health — Important Numbers That Shape the Future

Health care is a complex, dynamic business, for which government, individuals, companies and organizations pay. The good news is that, after leading the nation in the number of uninsured, health insurance coverage has expanded in Arizona in recent years. The bad news is that costs and spending are on the rise now after some years of stability. In 1998, Arizona's expenditures equaled 11 percent of the state's total economic output, while U.S. medical spending reached 14 percent of the gross domestic product in 2000.

Arizona ranked 35th in the nation in 2001 according to the UnitedHealth Foundation's State Health Ranking. Arizona is in the 10 best states in 3 of 17 measures, low prevalence of smoking, few occupational fatalities and a low incidence of cancer cases. The state placed 38th in 2000.

UnitedHealth Foundation, 2001.

With approximately 660,000 beneficiaries, Arizona ranks 27th in the nation on the number of Medicare recipients and places about in the middle of states on most Medicare measures. According to the Arizona Department of Insurance, Maricopa, Mohave, Pima, Pinal and Yavapai counties are home to the greatest percentages of the state's Medicare beneficiaries.

Table 8: Medicare Spending Per Beneficiary in Arizona is Less Than in Much of the Nation.

United States, Arizona and Top Ranking States on Medicare Spending Per Beneficiary, FY 2000

Area	$ Per Medicare Beneficiary	Rank
U.S.	**$5,490**	**NA**
Arizona	**$4,464**	**38**
District of Columbia	$10,373	1
Louisiana	$7,336	2
Florida	$6,937	3
New York	$6,924	4
Texas	$6,539	5

Source: www.statehealthfacts.kff.org. Centers for Medicare and Medicaid Services.

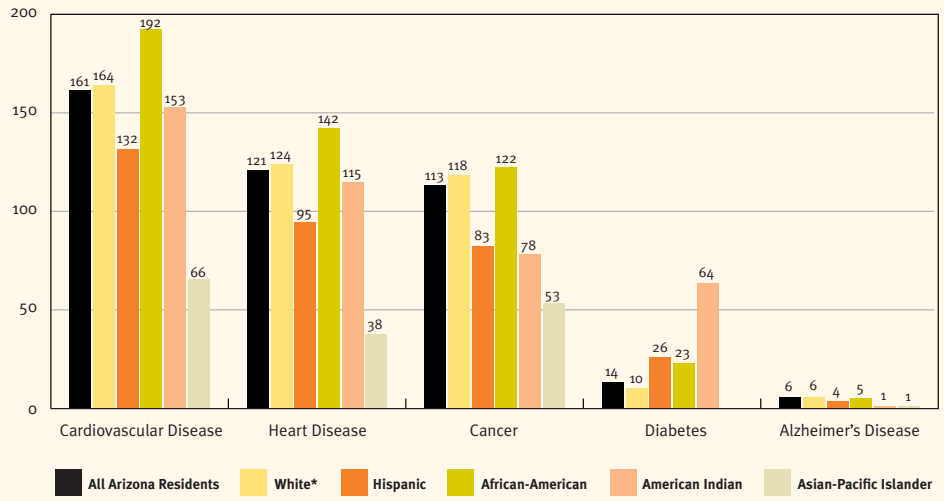
Differences in health appear among Arizona's racial and ethnic groups. In 1999, as in 1997, Arizona's Asian-American residents ranked best among ethnic groups overall in health status, followed by Whites (non-Hispanic), Hispanics, American Indians, and African-Americans.

Differences in the Health Status Among Ethnic Groups, 1999, Arizona Department of Health Services.

Arizona is by some measures healthier than other states. The overall rate of death per 100,000 in Arizona (461) is less than that for the nation as a whole (471). Fewer people smoke in Arizona than in many other states. On the other hand, although still less than the national average, fully half of Arizona's residents were overweight or obese in 1998. According to the Arizona Department of Health Services, arthritis and high blood pressure affect elders most often. An estimated 10 to 25 percent of older Arizonans suffer from mental health problems, such as depression and anxiety. Unfortunately, minority group members in Arizona, as across the country, generally suffer more health problems than whites. On another important indicator, the Arizona Department of Economic Security's Adult Protective Services unit received more than 14,000 inquiries in fiscal year 2000. Investigation substantiated 5,000 of these. People who are 85 and older are most likely to be neglected or abused, according to state data.

Figure 9: Diseases Affect Various Groups of Arizonans Differently and Point Toward Different Health Needs Among Elders.

Deaths per 100,000 in Arizona, 1999



* Non-Hispanic.

Source: *Differences in the Health Status Among Ethnic Groups*, 1999, Arizona Department of Health Services.

A Substantial Network: The Supply Side of Health Services in Arizona

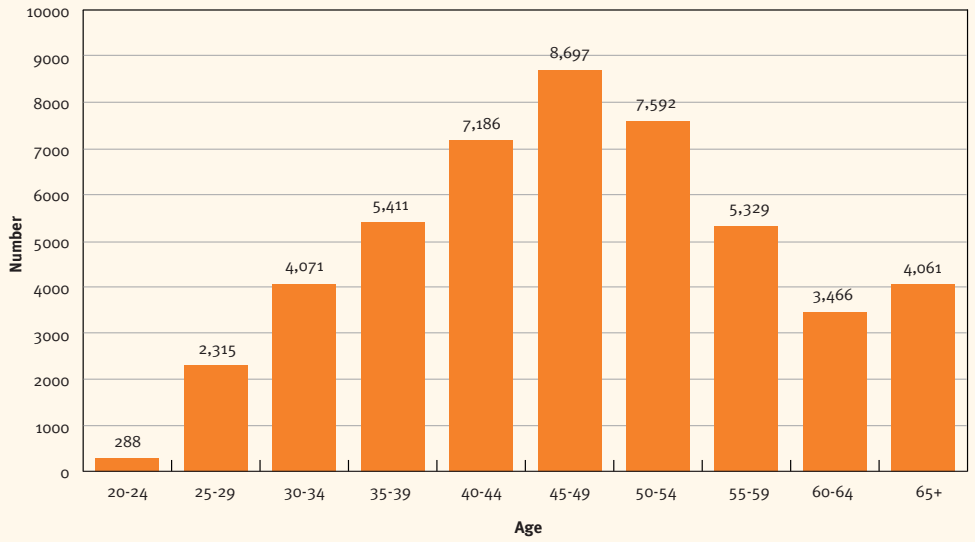
Arizona is home to more than 1,500 hospitals, clinics, nursing homes, and assisted living facilities. The number of facilities, though, does not tell the entire capacity story. For example, facilities tend to be clustered in urban areas. Three quarters of the state's hospitals are in metro Phoenix and metro Tucson. The Arizona Department of Health Services primary care data show substantial portions of the state's population live more than half an hour away from hospital services and cope with minimal services in the community.

Health Care Workers

Health care and community social programs employ nearly 200,000 Arizonans, but the state has fewer doctors and nurses per 100,000 than the rest of the nation. Arizona counts 628 active RN licenses per 100,000 population compared to 782 per 100,000 for the nation. The Arizona Department of Economic Security reports that it also is not a very stable workforce. In 1998, DES economists calculated that more health services workers left than were hired. The average worker's tenure was 13.5 months and the median was less than a year.[18] In addition, aging is an issue for workers. Soon, many health professionals will "age out" of the workforce.

Figure 10: Many Nurses Will Soon Reach Retirement Age. The Average Age of Arizona's Nurses is About 44. Who Will Replace Today's Middle-Aged Nurse?

Nursing Professionals by Age, 2000



*Includes broad range of nursing professionals, so the total may exceed the number of RNs in other figures.

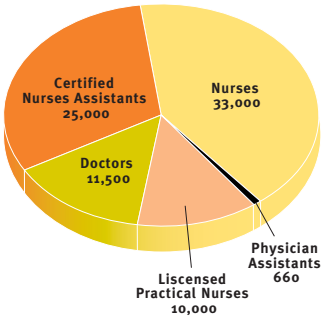
Source: Arizona Nurses Association.

Arizona Health Care: The Fiscal Side

With more than half of state revenues tagged for the necessities of K–12 education, universities and corrections in addition to spending required by voter-approved initiatives, competition will be stiff for more dollars for aging issues. On the other hand, long-term care obligations for low-income individuals will be hard to ignore. Figure 13, which presents the state's costs of long-term care, illustrates the coming problem. While these costs are relatively small — compared to a state budget of more than $7 billion — and rates of increase are stable, both are substantial considering the state's scarce resources and limited options for discretionary spending.

Figure 11: Skilled Workers Drive Health Care.

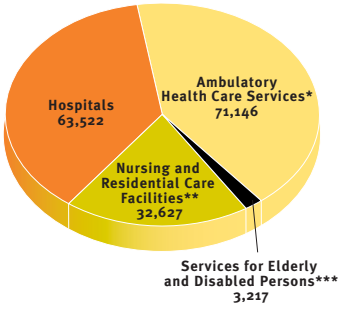
Estimated Number of Workers in Major Health Occupations in Arizona, 2000



Source: Kaiser Family Foundation, Arizona Hospital and Healthcare Association, Arizona Board of Nursing.

Figure 12: Doctors' Offices and a Wide Variety of Services Employ the Greatest Number of People.

Arizona Employees in Major Health Sectors, 1999



* Ambulatory health services include all types of doctors' offices and out-patient facilities.

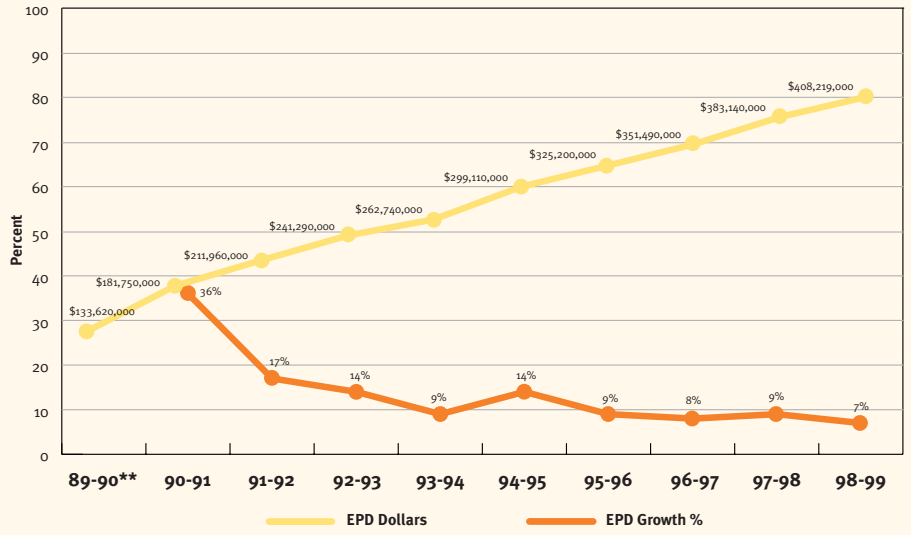
** Nursing and residential care facilities include nursing homes and other residences.

*** Services for elderly include community transportation, food and housing.

Source: County Business Patterns, 1999.

Figure 13: Arizona's Long-term Care Costs for Low-Income Elderly and Physically Disabled Beneficiaries Are on a Steep Upward Trend.

State Spending for and Growth of Elderly and Physically Disabled* (EPD) Long-term Care, Arizona Long-Term Care System, 1989-1999



* Elder beneficiaries account for roughly 60% and physically disabled 40%. The percentage of EPD growth shows the increase in beneficiaries between 1989 and 1999. The EPD dollars chart the state funds spent on elder and physically disabled beneficiaries between 1989 and 1999. The Arizona Long-Term Care System is part of the Arizona Health Care Cost Containment System.

** Program began 1/1/89.

Figures do not represent Native American program costs.

Source: *Community Based Services and Settings Report*, Arizona Health Care Cost Containment System and Arizona Department of Economic Security.

The Politics – Elders and Their Clout

Seniors traditionally have played a big part in public policy because they consistently vote more often than younger citizens. Considering baby boomers' political history, the next elders may even increase the influence of the over-60 set.

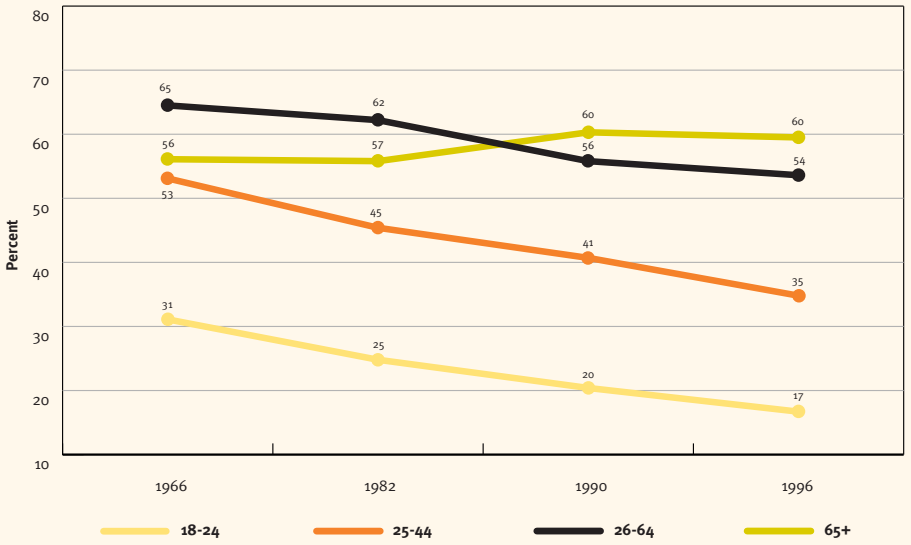
The facts and figures presented here represent just the tip of the aging, health and capacity iceberg.

- More growth
- More elders
- More diversity
- More costs

will strain Arizona's capacity to care.

Figure 14: Elders Have the Voting Habit.

Voting Rates by Age, 1966–1996



Source: Current Population Reports. *Voting and Registration in the Election of November 1998*, August 2000.

Mixed Messages About the Coming of Age from Professionals and the Public

Professionals and the Public on The Coming of Age

Talking with middle-aged Arizonans about aging brings up a variety of individual hopes and fears. For many, retirement and "elderhood" exist in the distant future. Busy caring for kids and earning a living, Arizonans, ages 40–59, have a lot on their minds, but stop them long enough to talk and there is a lot to learn. Professionals in health and aging fields also have much to say.

In October 2001, The Coming of Age project conducted focus groups in Phoenix, Tucson, Kingman and Safford with Arizonans ages 40–59. Recruited among the general public via telephone, the two-hour moderated discussions included men and women who are now caring, or anticipate caring, for elders, but also included some who did not expect to do so. Meetings with advocates and service professionals for the aged from throughout Arizona and another discussion among representatives from the Arizona Departments of Health and Economic Security, the Governor's Council on Aging and the Arizona Health Care Cost Containment System completed the qualitative research.

Also in October, the project conducted a statewide, representative telephone survey with 501 Arizonans ages 40–59. This age range was chosen to obtain the views of the "super-sized" boomer group, which is now so close to retirement age. The survey methodology is described at the end of this report.

Tomorrow's Elders Discuss Aging: Focus Group Themes and Comments

The four focus groups with almost 40 Arizonans raised many issues, but offered few solutions. These respondents shared many characteristics with other Arizonans. Many still had children living at home. Everyone worried about money. Saving for retirement may be a good thing to do, but many seemed to think, "I've got a lot more important things on my mind right now and more important bills to pay. I'll deal with that later."

"If You Don't Feel Old, You Don't Think about It Very Much"

The age that means "old" changes continually according to these Arizonans, and a person's condition often provides a better measure than their chronological age. "Twenty years older than I am" or "as old as you feel" often defined "aged." Those who gave a number put "old age" at about 75 years. Even though many respondents were caring for an elder relative, they had not thought about their own aging much.

Particularly for those with children at home, raising families ranked as their primary issue. Those, however, who had dealt with aging parents and other relatives, or were beginning to, were more likely to have thought about aging personally. Yet, denial is a persistent force in aging, health and even public policy. Those who are helping, or had helped, an elder relative often talked in terms of what they wanted to avoid. Preventing the negative situations endured by a loved one emerged as a strategy for aging more often than did a positive personal vision.

TALKING POINTS

- **Professionals in aging fields voiced concern that inadequate attention from top leaders, besides insufficient dollars and fragmented programs, has put Arizona on a collision course with aging.**
- **In a statewide survey of Arizonans 40-59 years old for The Coming of Age, only 18 percent said the aging of the population was a serious problem for the state, but it does present some personal anxieties to three out of four of those interviewed.**
- **Approximately 75 percent of those surveyed voiced some concern about their ability to care for an elder parent or relative, and 70 percent feared for their own financial futures. Arizonans with low incomes today expected to be the "have nots" of tomorrow.**
- **One-third of those in the survey cares for an elder now, and families are the most important source of care. Government (federal first, then state and local) has a part to play too, especially for those who are poor. Medicare, unfortunately, was seen as "iffy" for baby boomers. Many Arizonans worry that public programs for elders are of dubious quality.**
- **Despite concerns, 79 percent of the baby boomers surveyed felt optimistic about getting older.**

If you don't prepare financially, you're going to be a burden on someone.

Phoenix Focus Group Member.

Older Is Looking Better Than Ever

"The older you get, the better old looks!" Respondents saw their aging as being qualitatively different from, and better than, the experience of their grandparents and parents. People take better care of themselves now, and older people today have more options. Technology and knowledge lead to better, longer lives.

Depending on Healthy Aging

The benefits of diet, exercise and preventive measures were well known and widely associated with aging well. The great majority of participants talked about such things as "taking care of myself" in such ways as taking vitamins, exercising and eating well. Prevention appeared to function almost as a substitute for planning. People may have seen problems befall others close to them or been involved intimately in providing care. When that time ended, however, many seemed more likely to heave a sigh of relief and hope nothing similar ever happened to them than to make plans for themselves. For example, only one respondent spontaneously brought up long-term care insurance as a means of preparing for old age. Many had not even heard about such coverage and recoiled at its possible costs. The common belief that government, if necessary, would pick up the costs of elder care, made such an investment seem unnecessary. The bottom line is that health determines whether later years are good or bad and taking care of oneself is synonymous with long-term health.

The prevalent belief was that, even though aging was a family matter, those who could not cope with the situation should expect government to help them.

Aging in Place, At Least for Now

Most respondents had thought little about where they might live in their older years. Most seemed likely to stay in the same area — even the same house — as before retirement to be close to "roots and family and climate." But the aging-in-place outlooks may have had more to do with their not having given the subject much thought than with a definite plan. Respondents in the urban areas sometimes mentioned moving to a rural area, usually as a get-away-from-the-rat-race strategy, although they were slow to reflect on the health care options in smaller towns. Safford residents wanted to stay put, despite the recognition that medical care likely would be better in bigger cities with more options for insurance. On the other hand, the fact that everyone knows everyone in a smaller community meant that it would be easier to get the care they needed and they would be less likely to suffer any type of abuse in a care center. Kingman participants, however, voiced concerns about their town as a good place to age. Some members had experienced problems with local health care providers and, as a result, did not see the area as offering quality medical care or support for elders, despite its traditional reputation as an inexpensive place to retire. Discussion touched on the difficulties of getting around the community at older ages in a place without transit or reasonable alternatives to cars. In addition, members told about acquaintances who were healthy when they moved to Kingman, but were now having money and health problems. Lack of information and support made their lives difficult.

Worrying about Future Losses

Participants expressed vague concerns about growing older, including losing the ability to do what they today, not having sufficient money to enjoy their retirement years and fears of being a burden on their children. A few respondents also feared that they might have to be caring simultaneously for their parents and their children. Financial fears stemmed from not having enough money to enjoy retirement and not being able to afford the medical treatments that might prolong an active lifestyle. Many respondents, particularly those still in their 40s and early 50s, worried about whether Social Security and Medicare would provide them with the benefits that their parents received. Government played a big part in discussions about aging. The prevalent belief was that, even though aging was a family matter, those who could not cope with the situation should expect government to help them. But the potential costs to federal, state and local governments, and thus to them as taxpayers, were not well understood.

Aging Brings Physical and Mental Problems

When people thought about aging, they referred first to physical and mental problems. Money was a secondary issue. These Arizonans referred to the costs of nursing care, prescription drugs and other items, but the common image of an older person coping with "the problems of aging" was of someone who to some degree was physically or mentally incapacitated (or both). A healthy individual who could not afford food, shelter or routine medical care rarely surfaced as someone suffering the problems of aging.

The greatest financial concerns emerged among those without health insurance. These participants appeared to belong to the working poor who could not afford coverage. These Arizonans were keenly aware of the high costs of health care and foresaw difficult times ahead because of their lack of health insurance.

Families Care First — Government Cares Last

First and foremost, these participants saw families dealing with aging. When families cannot do so, complications set in. Most respondents said that government (federal government first) should then step in, although public programs were viewed as of dubious quality. There seemed to be little middle ground between family care and the risk of government-sponsored programs. Churches and community organizations were mentioned rarely, and only a very few who had dealt with family members with extensive needs knew of various options such as programs through local senior centers or the Arizona Department of Economic Security.

Government stood as the caregiver and the payer of last resort.

Government stood as the caregiver and the payer of last resort. A number of respondents quickly identified what government could do if we would just "get our priorities straight" as a nation. Costs of government programs or the consequences of many citizens needing care did not figure into their thinking. It was also acceptable among many to "spend down" resources to protect individual assets and take advantage of government programs. To one Safford respondent, if government helped families earlier, no one would have to "cheat the system."

"An Opportunity, Not a Disaster" for Arizona

Most did not see an aging population as a problem for Arizona. Indeed, some argued that entrepreneurs would rush in to serve a large market.

Most did not see an aging population as a problem for Arizona. Indeed, some argued that entrepreneurs would rush in to serve a large market. Similarly, there was little concern that the health care system would be overwhelmed, although some mentioned the need for additional workers. Elders were perceived as needing care different from that required by other residents, so the two groups have limited effects on one another. After all these years of appearing to court seniors, Arizona should be prepared to deal with more older residents.

Respondents had difficulty articulating how an aging population would affect the state at all. A reduced tax base because of an older, nonworking population came up most often. Few acknowledged an older population's need for more services that could strain that reduced tax base. Less need for schools would offset tax losses in part. Increases were seen in the need for senior housing, regulation of care centers and other senior services and perhaps in law enforcement. These did not, however, represent major costs. A few respondents pointed out that the elderly could be a potent voting bloc that could force the state to provide what they wanted. Most respondents, however, did not foresee problems for programs that an older voting bloc might not consider important.

The effects of rapid population growth colored opinions significantly. Growth was a top-of-mind topic statewide. All of the respondents had watched Arizona become home to more and more people. With the sheer number of new Arizonans being so big, few focused on the issues presented by changes within the state's population. These respondents were not all antigrowth. Growth just loomed large in their experience. Having more residents in Arizona appeared to be a bigger deal than having more elders.

Having more residents in Arizona appeared to be a bigger deal than having more elders.

Those who had experience with an elderly relative (primarily parents or in-laws) talked about the many challenges inherent in elder care.

Care limited the lifestyles of the caregivers, and they felt worn out, but few had looked very far for assistance.

Today's Caregivers Know the Challenges, But Not Many Resources for Assistance

Those who had experience with an elderly relative (primarily parents or in-laws) talked about the many challenges inherent in elder care. Care limited the lifestyles of the caregivers, and they felt worn out, but few had looked very far for assistance. One Phoenix-area daughter expressed surprise and gratitude at having found help from a social worker at a local senior center. Hospices and food banks came up, but the list of helping organizations was limited, at best. As one respondent noted, caregivers do not even know what questions to ask. The recommendation was made for some sort of information center on aging. However, the feeling was more "we could use some help" than a demand for "somebody's got to do something!" Everyone, as expressed in these groups, must simply endure aging and caregiving as best they can.

Professionals See a Different Picture of Aging

Denial as a Substantial Barrier

Professionals in the aging, health and caregiving fields agreed that a potential disaster could be prevented if policies and programs were changed to emphasize prevention, independence and flexible, integrated services and if the public thought more about aging. Unfortunately, denial clouds the vision of too many Arizonans. Lack of interest in planning and the assumption that someone will care reportedly make it difficult to engage people in these issues. However, if Arizona stays on its current path, many of these professionals foresaw situations so bad that one person said, "It makes my blood run cold." Arizona's problems mirror those of the entire country. On nearly every topic — from health care costs to workforce to increased care needs of the mushrooming elder population — "there is no reason to think that Arizona is better than the nation."

On the other hand, some professionals thought the baby boom generation is big enough to change systems for the better now that it is their turn to age. Regrettably, despite the "healthy, wealthy" stereotype, the diversity of Arizona's boomers could lead to a deep divide between "haves" and "have nots" and reduce the next elders' political clout.

Professionals complained that aging issues have been relegated to obscurity in Arizona. This lackadaisical outlook may be the downside of two laudable trends, namely improved attitudes about aging and more awareness of healthy lifestyles. But, professionals did not see "taking care of oneself" as a substitute for preparation or help when people need it. Today's professionals feared the consequences of worker shortages on one hand and on the other hand residents being "trapped by a culture of independence" and thus unwilling to seek help. The "unlimited youthful spirit" that motivates people to move to out-of-the-way places without thinking about the resources they might need if their health fails further enhances a rosy vision of a problem-free old age.

Unfortunately, crisis is inevitable according to those whose clientele consists mostly of people who moved to Arizona, or to an isolated part of the state, when they were part of the "young old" and are now part of the "old old" without local support or family. These participants were disappointed that the commitment to serving people once they became residents seemed less than the effort perceived to be spent on attracting them.

Professionals dealt frequently with what they called the "if I get sick, I'll get well...if not, Medicare will take care of me" myth. Residents fail to investigate or understand Medicare, but also do not want to spend their personal resources on care. Recent changes in federal rules have complicated the delivery of health services, and professionals reported coping with increasingly complex situations and the disappearance of service providers. As a result, personal resources are more important than ever before.

A Leadership Challenge

Professionals see a clear set of critical issues for aging and health care, all of which cry out for leadership:

- Failure to develop a "cost-effective continuum of care"
- Fragmentation of dollars and services
- Artificial boundaries between programs
- Inadequate strategies to support successful, productive aging

Leadership needs to emerge on these issues. One suggestion was a broad-based, state-level commission that could "declare the system is broken" and then develop solutions for Arizona. State and local coordination should come before trying to make changes at the federal level, and raising public awareness should precede substantial public policy changes in Arizona.

Some professionals thought that those in the "aging business" had spent the past 40 years isolating themselves from advocates for other target groups with complementary agendas. Federal statutes, because of their funding for aging programs, have dictated how networks developed. Services based on "chronology" have split off professionals in aging from those helping children, when youth and old age should be seen as parts of the same process.

Fortunately, advocates, professionals and even neighborhoods are creating new capacity in Arizona in response to current situations. Some foresaw the current challenges as perversely positive because they would force organizations to "learn how to be community-based again." For example, a Direct Caregiver Association now exists to support these workers. A state-level Older Workers Task Force with workforce professionals and business representatives meets regularly. The Pima Council on Aging is now acting on recommendations from a recent study commission. In Tucson, an established neighborhood's association has implemented a Minnesota program that supports elder residents remaining at home through help from neighbors.

A success story about substantial changes in foster care provided an example that several thought could be a model for solving complex problems related to aging. Led by Governor Hull's office, a few state agency representatives worked together to devise foster care solutions after advocates had helped to identify the issues. Development of new approaches took place out of the spotlight and solved what had seemed to be intractable issues.

The professionals who worked for the state's major public programs and a large corporate provider of assisted living echoed many of the concerns of their community colleagues. Frustration with the lack of personal planning and too little high-level attention to aging issues surfaced quickly. For the future, Arizona must face workforce issues, a potential HMO crisis, widening gaps between "haves" and "have nots," and a choice between cheaper community-based programs and more costly nursing homes.

The most important actions suggested for Arizona now included:

- Developing leadership and awareness
- Deciding what the state's public and private infrastructure must be to provide the care needed in the future
- Earmarking a dedicated funding source for aging issues and services
- Committing to keeping people in their homes and providing community-based services
- Making long-term care insurance a viable option for residents
- Deciding how to define and track "success" in aging

Despite their frustrations with the present and their concerns about the future, these participants were not without optimism. They saw Arizona as still having the opportunity to change.

Professionals Suggest the Following Changes in Arizona:

- **Recruit and retain service providers**
- **Use paraprofessionals to experiment with ways of reducing dependence on scarce health professionals**
- **Raise the pay of caregivers or provide monetary, tax or other incentives to encourage it**
- **See elder care as an opportunity, rather than an end-of-life burden**
- **Combine physical and mental health in programs**
- **Support research on chronic diseases**
- **Promote the desired personal actions through financial incentives**
- **Streamline regulatory systems to reduce workforce pressures and allow faster responses to changing marketplaces**
- **Increase support for and research on aging issues at Arizona's universities**
- **Strengthen current public and private, nonprofit institutions involved in aging work**
- **Recognize the differences between rural and urban areas in the scope and nature of issues and in potential responses to them**
- **Identify the differences between frequent users of health and aging services and others to allow for preventive treatments or new approaches to chronic illness for some and strategies to maintain wellness among others**

Nationally, about a quarter of adults with a parent over 65 help with financial and health decisions.

Kaiser Family Foundation.

The View from Middle Age: Attitudes of Arizona's Boomers

A statewide, random sample of 501 Arizonans, ages 40–59, participated in The Coming of Age telephone survey. The interviews focused on:

- Current or near-term family caregiving
- Care for themselves in the future
- Options for Social Security and Medicare
- Overall outlooks on aging and the future

Approximately one-quarter of these Arizonans lacked any parents, siblings or children within a 30-mile radius. Over half, however, reported one to five immediate family members close by, and about one in five counted at least six family members in the area.

The survey explored the thinking of those who are part of "tomorrow's" elders. Not surprisingly for this age group, more than 80 percent of the survey respondents worked. Just six percent said they were retired already. Slightly more than eight out of ten have children or stepchildren. Nearly three-quarters of the respondents have one or both parents still living, although, of course, not all in Arizona. Indeed, approximately one-quarter of these Arizonans lacked any parents, siblings or children within a 30-mile radius. Over half, however, reported one to five immediate family members close by, and about one in five counted at least six family members in the area. Of those without living parents, one-third saw the potential to care for another elder person. Now almost one-third of respondents help an older person in some way.

The greatest number of respondents (37%) described themselves as politically moderate with another third saying conservative. About one in five considered themselves to be liberal. More than half noted their membership in a church, synagogue or other religious institution.

More Aged Residents Won't Make Much Difference to Arizona

When asked to judge whether the large number of aging baby boomers was a problem for Arizona, respondents saw the situation almost as much of an opportunity for Arizona as it was a problem. Thirty-two percent viewed aging as a potential problem for the state compared with 23 percent who thought it offered an opportunity. The highest percentage (38%), though, did not think the demographic change would make a difference. Of the 32 percent who considered aging to be a problem for Arizona, more than half of these respondents (and thus 18% of respondents overall) considered it to be a serious one.

The respondents voted often, and approximately four in ten respondents volunteered at least four hours per month.

Aging Presents Anxieties Though, Especially About Money

On a personal level though, aging presents anxieties about caring for others and for themselves, and alarm rises sharply for those with less income. Nearly three-quarters (74%) of those interviewed expressed some concern about their ability to care for a parent or other elderly person important to them. Money worries created anxieties for good reason. Only about one in four (28%) felt that the person for whom the respondent was concerned was "very able" to handle their own care needs financially. Just seven percent said they felt "very able" to cover the costs of care for a relative or friend themselves, as opposed to 33 percent who felt "not very able."

Nearly three-quarters of those interviewed expressed some concern about their ability to care for a parent or other elderly person important to them.

For themselves, 70 percent answered they were very or somewhat concerned about their ability to pay for their own medical and living expenses when older. Fear related to income, with just 12 percent of those with household incomes over $80,000 voicing strong concerns, compared to 62 percent of those with less than $20,000 in annual income. The thought of being squeezed between children and aging parents (or some other elderly person) disquieted some respondents. More than four out of ten said they were very concerned or somewhat concerned about caring for elders and children at the same time.

Respondents Care for Elders Now

Experience with elder care is widespread. One-third of respondents assisted an elder at the time of the survey, including running errands, housekeeping, maintaining property and the like.

One-third of the respondents had assisted a person financially with nearly as many (27%) having taken control of the person's finances. Slightly over one in five have brought a person to live with them, and 17 percent have admitted a person into a nursing home.

Care is a family matter, especially among Hispanic respondents. The most likely response to a need for care among all of the respondents (38%) was to have an older person live with them. Similar numbers of respondents (from 25 to 29%) said it is very likely a person would live in their own home, an assisted living facility, or with other friends or relatives. Asked what would happen if the person tried to remain in their own home but could not, only one in ten of these respondents felt that the person would be cared for in a nursing home, about the same number who thought the person would be cared for in their own home by hired professionals. Nearly all (92%) agreed that government should provide tax breaks for those individuals who care for an elderly person with 72 percent saying they strongly agreed.

More than four out of ten reported being very concerned or somewhat concerned about caring for elders and children at the same time.

Starting to Prepare for Aging, If There's the Money

Respondents reported being at the beginning stages of preparing for their own aging. The largest percentage (47%) said they had saved for long-term care needs. Again, income made a difference. Just nine percent among those in the under-$20,000 income bracket said they had put money aside, versus 68 percent in the over-$80,000 income group. One in three had discussed the help they might need with children, another close relative or friend. Eighteen percent said they had investigated assisted living centers, the same percentage as said they had investigated government assistance programs. Two-thirds (64%) of the respondents indicated that they had created a financial plan beyond their employer or Social Security. Again, substantially more higher-income respondents said they had made a plan compared to the less-affluent respondents. In addition, 84 percent of those with a postgraduate degree said they had planned versus 49 percent of those who had not attended any college.

Nearly all (92%) agreed that government should provide tax breaks for those individuals who care for an elderly person.

Most of those with children believed that their kids would be at least somewhat helpful in their old age. One-third (35%) anticipated their children would be very helpful; 45 percent, somewhat helpful. About one in five (17%) said they expected their children to be "not very helpful."

About one in five in the survey said they expected their children to be "not very helpful."

More Income and Education Mean More Optimism

Respondents understand the phrase "healthy, wealthy and wise." Overall, these Arizonans perceived themselves as healthy. Twenty-five percent reported being in "excellent" health and 41 percent said their health was "very good." Only 10 percent called their health "only fair" (6%) or "poor" (4%). Those respondents in the lowest income group were more likely to say that their health was fair or poor than good or excellent. Among those with the highest incomes, fully 74 percent called their health excellent or very good. Those with the highest level of education more often described their health as "excellent" (42%).

Among all respondents, four of ten (39%) said that they were "very optimistic" and a like number (40%) said "somewhat optimistic" about getting older. Only 19 percent said that they were neutral (4%), "somewhat pessimistic" (11%), or "very pessimistic" (4%). Good health (33%) was the main reason for optimism. Good health led to an optimistic view of the future. Of those who said they were very optimistic, 83 percent also reported being in excellent or very good health. Only five percent of those who reported fair or poor health expressed optimism about the future, but 24 percent expressed pessimism.

Respondents' reasons for optimism about getting older read like a primer on successful aging: fine health, positive attitude, good medical coverage, future plans, financial security and strong families. The most important component is health. "As long as I am healthy" is the watchword for respondents.

Most baby boomers don't expect big changes in lifestyle after retirement, but with increases in longevity and the current economic climate, that may not be true. In addition, we know that people are saving less than previous generations and that the move away from employer-sponsored pension plans could mean less income in retirement. Relatively few Americans are protecting their assets by investing in vehicles like long-term care insurance.

MetLife Mature Market Institute, 2001.

About 80 percent of Arizonans are optimistic about getting older. Overall, Americans feel good about elderhood as well. A 2001 nationwide survey showed 63 percent of Americans would like to live to be 100 years old. 60 percent of respondents expect to enjoy life more as they age by spending more time with family and friends.

Source: Zogby International, 2001.

***The Coming of Age* Participants Were Optimistic – or Not – for the Following Reasons:**

- **I am trying to make good health choices now to help assure good health as I get older. Also because I have good medical care to keep me healthy.**
- **I'm pretty good in my health, and I'm in school to fix computers.**
- **Because of my good health, the miracles of modern medicine and because I plan to be financially prepared for retirement.**

Some are not so positive:

- **My age and my disability... now I need the benefits and they keep switching the insurance around. If not for my disability, I would be very optimistic.**
- **I have to work until I drop.**
- **Because of my low income, I don't know how I will manage. I scrape by now. I don't think I make enough to survive.**

Sources of concern or pessimism reflect the effects of health problems, the complexities of health insurance, fear of old age and current financial worries.

Long-term Care Insurance Among Just Six Percent

Over three-quarters (77%) of these respondents claimed to have heard at least something about the concept of long-term care insurance, with 33 percent saying that they had "heard a lot." Six percent said they had purchased a long-term care policy, which is comparable to some national data, such as that from the Health Insurance Association of America, but far more than reported by the Arizona Department of Insurance.

Government Owes Elders, But Medicare Is "Iffy"

Government should see that all elderly people have adequate health insurance, regardless of their ability to pay, according to these Arizonans. Overall, 88 percent agreed with the statement with 63 percent agreeing strongly. However, almost half (45%) of those interviewed said they felt it was only "somewhat likely" that Medicare would be available for them in the future. The remainder split almost evenly between those who said "very likely" and "not very likely."

Asked about what Medicare covers, 83 percent said that Medicare pays for hospital care; 75 percent said Medicare pays for routine doctor visits; 53 percent said it pays for home health services; 30 percent said Medicare pays for nursing home care for an extended period. When told that Medicare indeed does not cover the costs of all types of nursing home and home health care, respondents widely supported covering these costs. Fully 87 percent thought that Medicare should cover all home health care costs. These respondents were almost evenly split regarding whether the costs should be paid for all seniors (47% said they should) or only for those who are truly needy (50%). A smaller, yet still large, percentage of respondents believed that Medicare should cover the costs of nursing home care (77% yes, 16% no). Respondents were more likely to say that payment for nursing homes should be limited to those who are truly needy (53%) than to all seniors (44%).

Table 9: Few Want to See Elders Pay More for Medicare.

	% Favor	% Oppose	% Don't Know
Creating a sliding scale for Medicare premiums	70	25	5
Reducing payments to doctors and hospitals	55	37	7
Raising the age of eligibility from 65 to 67	41	56	3
Increasing the payroll taxes of workers	38	58	5
Limiting the amount Medicare contributes toward health insurance to a fixed amount per year	27	63	10
Charging more for seniors who use traditional Medicare programs to encourage a move to Medicare HMOs	24	62	13
Requiring seniors to pay a larger share of costs out of their own pockets	17	79	5

Source: The Coming of Age Survey, October 2001.

In some ways, then, asking others — more wealthy seniors, doctors and hospitals — to pay more of the cost of care for the elderly was favored, although respondents on balance rejected increasing the payroll taxes of workers. It is interesting to find that, although a sliding scale was widely supported, a variation of this idea — requiring seniors to pay a larger share of the costs out of their own pocket — was rejected. The survey does not tell us whether the wide difference in opinion is that the sliding scale implicitly referenced seniors with higher incomes, whether respondents saw a difference between "premiums" and "costs," or whether some other factor was operating. Concerns abound about ability to pay, but the messages about who should pay decidedly are mixed.

Some Want to Work — Some Want to Retire

Close to half (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. This may relate to the fact that almost half of the respondents (48%) indicated they were only "somewhat confident" that they would have enough income when they retire. In a national survey of baby boomers by the Del Webb Corporation, concerns about money were at the root of continuing to work for many. Two-thirds of the national respondents said they were likely to work 20 or more hours per week because they did not feel that they would have enough money to retire at 55.

Health Insurance and Money Make Work Attractive

Of those respondents 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 played a very important part in their decision (another 28% said that it was a somewhat important factor). Of those who said they will remain in the workforce, half (49%) said they would do so solely because they wanted to work. The other half (51%) indicated a need for income, for benefits or for both.

The Federal Government Should Provide for Low-income Elders

Asked who should be most responsible for bearing the health care costs of low-income seniors, more respondents (36%) said that it was the federal government's responsibility than any other group or level of government. Children were seen as the next responsible group (23%). State and local governments came up less often (9% and 3% respectively). Fifteen percent of respondents thought a combination of institutions and people should be responsible. For those who said that children should have primary responsibility, the question was asked who should be responsible if there were no children. In that situation, 30 percent said the federal government should step in, followed by state government (23%) and local government (9%). In a "childless" situation, 14 percent put the responsibility in the laps of religious institutions and 8 percent looked to community organizations. Government should provide health insurance to all elderly people, but make high-income seniors pay more in premiums, according to 63 percent of respondents. Slightly more than half (52%) of the respondents rejected the contention that government should provide adequate health insurance only to low-income seniors. However, 46 percent agreed.

Rural Attractions for Retirement

Directly after retirement, more than half (52%) said they planned to live in the same house as before retirement, with 11 percent in a different house but in the same community. About one in four indicated plans to live in another community (13%), another state (12%), or another country (2%). Eleven percent did not know. Among the movers, planned retirement communities are not a favored destination in this survey by a wide margin (only 25% expressed interest in a retirement community). Communities with children also win out over those without. Fully two-thirds of these movers said that they expected to live in a rural area, rather than an urban environment.

Doctors and specialists ranked as the most important feature of a positive retirement place, and availability of an acute-care hospital was not far behind. The lowest importance was assigned to being close to big city amenities, such as an airport, museums and sports teams. Only 22 percent said that this was very important.

Table 10: Health Care is a Vital Component of Any Retirement Place.

Characteristics	% Very Important	% Somewhat Important	% Not Very Important
Availability of family doctors and specialists	66	28	6
Cost of living	61	32	7
Availability of an acute care hospital	56	34	10
Being close to one's children	54	25	16
Being close to other family and friends	50	35	15

Source: The Coming of Age Survey, October 2001.

Arizonans are in tune with the nation on help for those with lower incomes and keeping Medicare costs down. A Kaiser Family Foundaton survey reflected essentially the same numbers nationally on the issues presented in Table 9.

Source: Kaiser Family Foundation.

Half of the Arizona survey respondents want to retire, and half want to continue working.

Among those who expected to move upon retirement, planned retirement communities are not a favored destination in this survey by a wide margin. Fully two-thirds of these movers said that they expected to live in a rural area, rather than an urban environment.

Some would see a contradiction between the attractiveness of a rural retirement home and the fact that availability of doctors is the most important characteristic of a positive place in which to age. Many rural areas may not have all types of doctors and specialists available in addition to a full-service hospital. As noted earlier by the professionals, responses to these questions may demonstrate that "unlimited youthful spirit," as well as denial that there is a gap between wanting both easy access to medical specialists and an out-of-the-way retirement place.

Religious Differences in Elder Care

Half of the respondents said they belong to religious institutions. These respondents are somewhat more likely to identify a religious institution as a source of help as they age. In addition, members of a church or religious institution are slightly more likely to be providing elder care now than other Arizonans.

Contradictions Abound

Tomorrow's maturing boomer/elder population is a diverse lot. Not surprisingly, these Arizonans hold some contradictory outlooks on aging. For example, aging isn't a problem for Arizona, but personally it appears to be putting quite a few on edge. Respondents report (although it is easy to overstate actions to an anonymous telephone interviewer) having done more preparation than might have been expected based on the stories told by the professionals. Arizonans, however, do not seem to feel or to be well prepared financially for caring for another person or themselves, and those at the low end of the income scale clearly are worried about being tomorrow's "have nots." In fact, looking at today's less educated, low-wage workers provides a snapshot of what tomorrow's needy seniors most likely will be. While families now appear to be rising to the occasion of caring (or are ready to), having children is no guarantee of help for a sizeable number of people. Many may simply be assuming that their children will assist them.

Those who want to work and those who want to take it easy split evenly, but the actual need to work may be higher than realized considering the responses on savings and long-term plans.

Government has to play a role in aging according to these respondents. The message is mixed though about whether that role should be for everyone or just for those who cannot afford to care for themselves. Even if Medicare is "iffy," the federal government is viewed as a primary source of payment for health and elder care.

Aging in place will be the norm for most Arizonans, although the desire to move to a small town is evident. The comparison of what makes a good retirement place, though, shows up some important contradictions.

For those with health and wealth, aging is the next stage of life. For those who lack both, the next decades do not appear as rosy. Even those with more resources have concerns and see government as a player in paying for care and supporting their quality of life. Thus, these respondents underscore the importance of planning as a state and exploring whether our communities are ready for more elders.

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

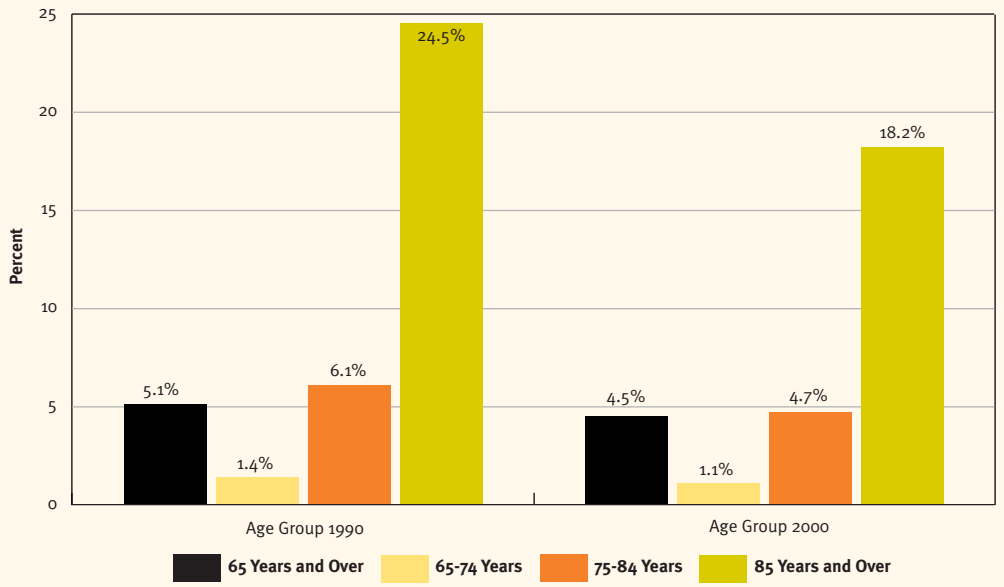
Source: Medicare Current Beneficiary Survey. *Older Americans 2000: Indicators of Well-Being.*

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.

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.

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.

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.

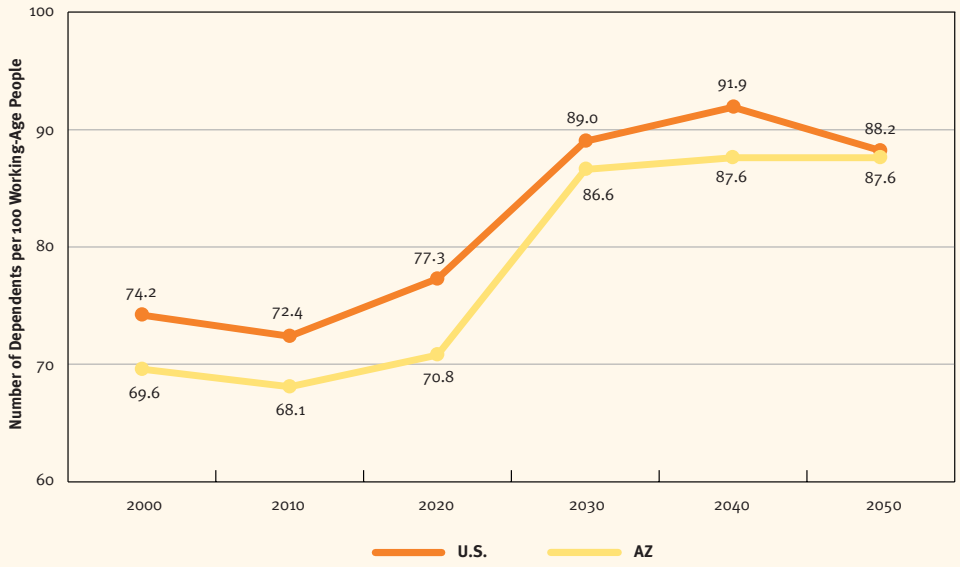
contribute to higher health care costs.[52] Yet Medicare leaves out drug benefits and does not cover long-term care costs. Seniors with the best of the "Medigap" supplementary policies may have drug benefits, but this situation leaves out less affluent seniors.

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.

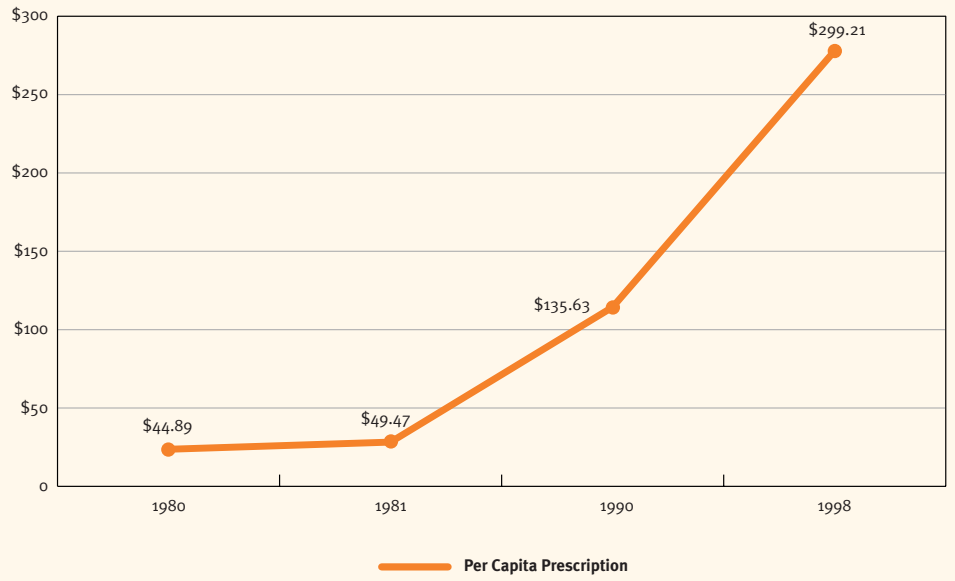
By 1998, though, Arizona had caught up, spending 9.5 percent of personal health care expenditures on drugs to the nation's 8.9 percent.

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]

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.

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.

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.

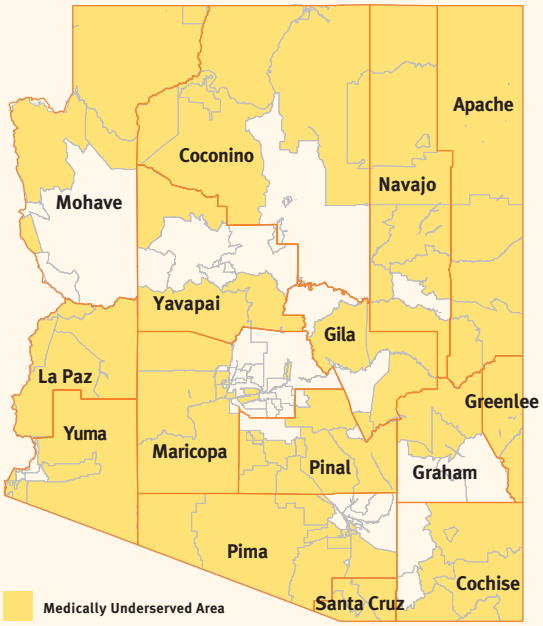
Kingman Focus Group Member.

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.

It's Time: Arizona Needs to Talk and Choose

Time to Choose

Arizona, a remarkably robust and still relatively young state, is graying. *The Coming of Age* candidly captures many mixed messages; it is honest about the uncertainties that lie ahead. But it is no false alarm. The aging of Arizona's people uncorks a cascade of consequences on public and private systems, on institutions and their finance and on families and individuals.

No one knows how the scene will look by 2030. Who, though, can deny that 2030's conditions will be shaped by the choices Arizonans make in the next few years? Some put more faith in market choices than in government decisions, while others would reverse the two. Neither is separate from the constraints and incentives that stem from the myriad decisions of families, communities, businesses and public agencies. Decisions about health, savings, insurance and investments in infrastructure and institutions all add up. Can the people of Arizona, who care deeply about the state and quality of life, manage these choices to ensure the most positive outcomes for all?

Choices or Consequences

The easiest course is to do little or nothing. Confident that the future will work out, many would be tempted to follow the physician's maxim: "do no harm." The challenge, however, that aging presents to Arizona may be one of those times when doing nothing brings the greatest harm.

Doing nothing almost guarantees that significantly greater public costs for health care will eat their way through Arizona's treasury, devouring commitments to educating kids, taking care of roads and transit, and investing in infrastructure that nourishes the knowledge economy. The trend is headed that way, and no data suggest a change in direction or velocity.

Doing nothing assures an even wider gap between people with the resources to buy good care and those without. Governments, always under pressure to close these gaps, will find they are stuck with more rationing and triage formulas.

Doing nothing inevitably will damage the state's quality of life. That could influence the future in-migration of younger people, something crucial for sustaining the vitality of the state. It used to be that any good place to work was a good place to live. These days, with footloose firms and choosy knowledge workers, only good places to live are seen as acceptable places to work. Arizona cannot afford to see its appeal eroded by unwillingness to act on the facts.

But isn't health care fundamentally a federal issue? Aren't Social Security (again) and Medicare up for review and reform? Amid the clamor by seniors for incorporating prescription drugs into Medicare and the push by professionals for flexibility to support home and community-based care and genuine case management, won't there be changes at the top? Can't we wait for that?

Not when health care already consumes eight percent of Arizona's state budget. Even as leaders lobby for federal changes, states such as Florida, Minnesota and Pennsylvania are experimenting with shifting resources from acute care to preventive and self-care approaches.

The time has come for choosing how the state will prepare itself. What strategic investments are smartest at the state level, at the local level? It's time to realize that even the most intensely local decisions, such as zoning ordinances, either support or undermine smart strategy.

TALKING POINTS

Arizona needs to gather round and discuss the issues and choices of aging.

The big issues on the table should be:

- **Leadership**
- **Infrastructure**
- **Dedicated funding**
- **Elder independence**
- **Individual financial preparation**

Arizona's communities should prepare now by building their capacity to be elder friendly.

Strategic Investments

This analysis of trends should compel governments at every level and individuals of every age to tune in as advocates of change. The tendency of our national government to postpone even certain reckonings is playing out again, particularly on issues affecting our capacity to manage aging. We seem to be cutting programs (such as graduate medical education – in the face of a shortage of physicians) rather than reforming Medicare, even as public officials promise to add expensive new prescription drug benefits. There is talk of expanding Medicaid to address the needs of the working poor, but not much evidence of commitment to raising the required resources. So, while admitting the complexities of this "Rubik's Cube" of public policy, the stage does seem to be set for a more powerful organizing of voices demanding that the federal government own up to the fiscal realities of these programs.

Meanwhile, the search should be at full speed for strategies that would position the state and local communities to manage the coming challenges of aging. The Minnesota Department of Human Services' report, *Baby Steps to 2030*, has three simple but far-reaching goals:

- Provide older persons simplified and streamlined access to the wide range of care and support options available.
- Provide elder people with necessary information to make self-care decisions.
- Provide access and links to consumer advocates who advise older people on the services and organizations that best fit their needs and financial capacity.

The Internet already offers one of the foundations of preparation. From **www.caregiver.org** to **www.senior.com** to **www.aarp.org** and thousands of other credible specialized sites, help and information are just a click away. Such sites are certain to expand, and making sure of elders' connections to them should be a role for the right agency in Arizona.

Other investment ideas:

- Improve Arizonans' health to promote successful aging.
- Reduce the percentage of middle-aged residents without health insurance.
- Expand Healthy Arizona 2010 and positive public health messages.
- Provide incentives for family caregiving.
- Create a health care and service equivalent to "911."
- Encourage home and community-based solutions.

Certainly, it is critical to boost Arizona's economy and education options throughout the state to ensure a dynamic, high-wage future. In addition:

- Step up efforts to compete in the new economy and make Arizona a technology leader.
- Increase achievement and reduce drop out rates among all students.
- Encourage continuing education in all forms.
- Continue to revamp workforce training programs in health care.
- Create a new measure of GSP — gross service product — for Arizona to account for unpaid caregiving and community service.
- Encourage and train businesses on options for an elder workforce.
- Put the state government on a sound financial footing.

Even this short list of ideas, which surfaced during The Coming of Age project, reveals an important truth about the Arizona aging challenge: everything's connected to everything else. People tend to think of public policy issues in isolation. Today we worry about a tax structure with perverse

incentives; tomorrow we wring our hands over poor education outcomes. Next week we are shaking our heads over some community that straps a gate over its exclusive enclave and declares its autonomy. All these issues, and more, come together on the aging question.

So, in a state known for frugality with the public's money, it is vital to mold public investments into an integrated strategic whole to:

- Change the incentives and rules to make all communities friendly to people of all ages.
- Rebuild the tax-collecting machinery to be congruent with a 21st century economy.
- Make the infrastructure investments and policy changes conducive to developing the knowledge-based businesses that assure the greatest prosperity.
- Invest in the preparation of every willing resident for as sophisticated a job as each can handle.
- Insist on the policy modifications and funding necessary to make public programs for elders increasingly effective as the numbers grow.
- Identify practical personal long-term care insurance options and make them common knowledge.

Role of Elders in a World Short of Workers

Today's and tomorrow's elders are candid about the desire of some to continue working, and the necessity of it for others. But even in a world beset by shortages of workers, especially in health care, the public sector will have to make a series of strategic investments to facilitate basic opportunity. The key targets are technology and training. The same technology that makes medical diagnosis possible at a distance enables an elder to work at home, or from countless other locations.

This investment challenge is not limited to cable or telephone lines. There are barriers to remove, such as the disincentives to work imbedded in many government programs. Pensions and health care, as benefits, need to be designed to complement Social Security and Medicare, and these instruments have to be portable. Creative forms of reinsurance have to be developed, such as pools for businesses to facilitate coverage of part-time or seasonal workers.

Building Community Capacity

Senators and scholars and policy pundits hold conferences about the graying of America, and to listen to what's said, one would conclude that the puzzles and their solutions lie entirely in the realms of macroeconomics and complex public policy. This is true to an extent. But often the best response turns out to be the simplest one. In the neighborhoods of Prescott, Yuma, Mesa, Lake Havasu City, Winslow, Page or Tucson, one might find the most innovative ideas.

America has presided for fifty years, without any conscious plan, over a pattern of incipient separatism — the affinity principle running rampant over traditional community form. For many Americans with the affluence to choose, homogeneity is a real estate goal. It's been seen as the key to safety and stable property values.

In recent years, however, recognition has taken root that such places may not be communities with the capacity to support residents. While many will continue to prefer that lifestyle, there are serious signs that the market is shifting. Now, people are looking increasingly for places to live that are not anonymous house collections, where it is possible to walk without competing with cars, where some of life's amenities don't require an automobile to get you there. This "new urbanism" has become the hottest trend in real estate. It's not all that new, since, it is really a return to the traditional structure of a community. Even older suburbs are scrambling to retrofit community gathering places where none ever existed.

It's time to nurture a changed culture that supports elongated lives in much more creative, thoughtful and respectful ways.

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

What's the connection of this trend to aging Arizonans? These are communities that accommodate the full life cycle of housing. They're comfortable with differences. You expect to see old people, along with young. The grocery store and dry cleaners are within walking distance, as are the library branch, drug store, post office and maybe a small clinic or a school with continuing education courses. Today's elders remember these communities. Most grew up in them. Many are nostalgic about the old neighborhoods, while others who are younger are seeking to capture a sense of community they feel they've lacked.

The problem is that typical city planning remains hostile to nearly every aspect of this kind of community development, from the width of streets to lot and house sizes and to mixing the uses in a town center.

This can be changed, as can any other policy problem, with political pressure. Pressure to replace those ordinances with a code that describes the kind of community people want. These codes are now beginning to be adopted in cities and towns across the country.

In addition to rebuilding a sense of community through the design of housing, streets and town centers, communities could do a hundred other things to make themselves friendly places for elders to live – better lighting and larger type on critical signs, for example.

Communities are where volunteers live, too, and where community organizations whose mission it is to assist elders can best reach them. Most Arizonans responded to this project's survey with a strong sentiment to stay where they are. Strengthening communities may be the most cost-effective strategy for shoring up Arizona's capacity to care.

We Have to Talk

We can't deal with things we won't talk about.

Robert J. Samuelson.

This report provides a starting point. What has to follow is a steady tracking of core data, by categories of care and cost, by indicators of changes in individual and family preferences, by demographic shifts and fiscal capacity. Changes made in public policy must be measured for apparent impacts.

Serving the Age in Information Age

Information, however accurate, relevant and up to date, is worthless in this cause if it fails to connect with today's elders and those on the threshold. This calls for an interactive system that is accessible, transparent and visible. If it is a good system, people will find it and use it.

Talking To, Not Past, Each Other

In addition to quality information, Arizonans must find a forum for talking about choices. Many choices, such as whether to purchase long-term care insurance, are clearly personal. But information and support have to be there, even to contemplate the prospect of a purchase.

Some choices carry broader community implications. Can the public sector succeed in reframing the entire effort to reflect a commitment to "long-term support," rather than "long-term care"? What will people say if the state embraces a strategy that relies more on self-sufficiency, assumes better health in later years and encourages greater independence on the part of those who are able?

We need to assemble the multiple perspectives among elders, boomers, adults contemplating the potential frailty of their parents and others around a single discussion table. In a second ring, closely attentive to this conversation, we should find the leaders of institutions and organizations in the vast and growing health care sector, whose programs need to fit the market these perspectives produce. In the next ring come the policy makers who have to wrap the whole

arrangement into some reasonable statement of what's in the public interest, and sign the checks for what the taxpayers are willing to support.

Choices Come Hard

Our democratic system has many strengths. Unfortunately, efficiency of decision-making is not among them. So dedicated are we to checks and balances and due process that on many fronts we find a severely strained capacity for coming to a conclusion.

Generally, only crisis intervenes. Then the rules bend, hard lines of argument soften, and we find a working consensus. Somehow our society must learn to see crisis in waiting too long on something so important as aging. The issues swirling around the developing demographics of Arizona are a perfect case in point: by the time the general public would see the situation as a genuine crisis, it would be too late to do what needs to be done. Moreover, our slow, plodding and usually satisfactory governance habits may not be in harmony with the way the world works now. With communication happening instantaneously and flexibility, continuous innovation and rapid response the tools of social and economic survival, can governance not change too?

Arizona's pattern of aging is not a storyline for a play coming soon to a stage near you. It's a real-life certainty, hurtling toward a crash landing in this state's collective lap. If institutions are going to change, if budget directions are going to be reshaped, choices will need to be made soon. Later, will simply be too late.

Only by engaging people in direct conversations on aging is there any hope of overcoming the prominence of interest-group-driven politics. Only if the ground shifts under a stubborn status quo through the forming of a popular consensus will the change-oriented leaders of major institutions be able to overcome organizational inertia and the patterned paternalism of today's practices. Then it might be possible to see older people, not as clients, or "problems," but as partners in a new statewide community enterprise.

We Must Catch Up, Then Learn to Lead

Other states with similar challenges are acting. Florida, with its Department of Elder Affairs, has launched a multidimensional approach with an emphasis on helping local communities to become "elder ready." Similar work is under way in California and Texas. Minnesota's collaboration among the Department of Human Services with its *Aging Initiative: Project 2030*, the Citizens League of the Twin Cities and the Minnesota Board on Aging is pushing a wide range of policy changes. In March 2001, the American Society on Aging and the National Council on Aging cosponsored a conference showcasing best practices on the topics around which The Coming of Age project was organized. No Arizona examples were on the program.

This can and must change. Arizonans have to commit to an agenda for action. Otherwise, where are we, except trapped in a meaningless cycle of conversations, raising the same issues, providing recommendations, and seeing nothing adopted. Does anyone remember the Pritzlaff Commission of 20 years ago? They named the problems we still have.

Here, then, is an agenda for action:

- Develop leadership and public awareness.
- Decide on the needed public and private infrastructure and determine how to define success.
- Devise a dedicated funding source for aging issues.
- Commit to keeping elders in their homes and to community support.
- Make long-term care insurance a viable option for individuals.

Leadership and public awareness should lead an action agenda for Arizona.

It seems obvious that people want a different result, even as they behave as though they don't want anything to change. And that, of course, is part of the problem. On most complex issues, people want a significant difference in results without expecting any substantial change in how they do things.

One thing surely must change: the quality of public dialogue. If this report is to have value, it should become the subject of many public meetings in the coming months. Organizations should make it the subject of annual meetings. Service clubs should ask for speakers. It should navigate even the treacherous shoals of talk radio, and stay there long enough for facts to surface and get a little respect. After a period of reporting and talking, those who would be the leaders on this issue have to bring the disparate voices into a reasonably consonant choir.

Will you still need me, will you still feed me, when I'm 64?

Paul McCartney.

Public opinion expert Daniel Yankelovich argues persuasively that only an informed public has any chance of tackling the problems that confront us today. He says the need is for well-framed dialogues, the kind that "come to public judgment."[96]

The Coming of Age captures a picture of today as it contemplates tomorrow. It presents a complex issue to the good people of Arizona. It expects a response. Perhaps this is the issue through which Arizona politics, like its people, truly will come of age.

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Advocacy for Aging and the Elderly

AARP
www.agenet.com

ElderWeb
www.elderweb.com

Gray Panthers
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Long-term Care Campaign
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National Association of Area Agencies on Aging
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Survey Methodology

The survey of Arizona residents reported in this study was conducted by O'Neil and Associates between October 18 and November 12, 2001. A total of 501 Arizona residents were interviewed by telephone: 213 men and 288 women between the ages of 40 and 59.

First, 401 of the interviews were conducted randomly throughout the state. Then a supplemental sample of 100 interviews was done in the 13 non-metropolitan counties to assure that the views of residents of those counties were represented adequately. Following this over-sampling in the rural areas, the data were scientifically weighted to assure that the responses reflected how residents across the state reacted to the questions asked.

All surveys are subject to a variety of types of sampling error, with the so-called "margin of error" — being the most commonly discussed. It is the difference between the results obtained from a sample and those that would be obtained by surveying the entire population under consideration. The size of sampling error varies, to some extent, with the number of interviews completed and with the division of opinion on a particular question. For this survey, the overall sampling error at the 95% confidence level is ± 4.4%.

Projections Note

As described by the U.S. Census Bureau, projections are estimates of the population for future dates. They illustrate plausible courses of population change based on assumptions about future births, deaths and domestic and international migration. The projections used in *The Coming of Age* come from the Arizona Department of Economic Security Population Statistics Unit, the state's official affiliate of the U.S. Census Bureau. The data used here were the most commonly cited and best statistics at the time this report was prepared. New projections for Arizona and additional data from Census 2000 are expected sometime in the future. These new sources will provide more details about Arizona's dramatic population growth and clarify aging issues further.

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The Coming of Age is a multi-faceted project with many contributors.

Scholars and researchers created the items to the left as part of the yearlong effort.

Materials are available at www.slhi.org

The purpose of *Arizona Health Futures* is to unravel an important health policy topic of relevance to Arizonans, provide a general summary of the critical issues, background information and different perspectives on approaches to the topic; tap into the expertise of informed citizens, and suggest strategies for action.

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