From the Field

Gerontological Health, Disability, and Managed Care

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This essay is based on participant observation, on the reworking of some survey results published earlier, and on conclusions which are drawn from both of them. It presents a solution for people defined as elderly (generally 65 and over) to problems of managed care. The author identifies as a person with a disability (wheelchair user from polio) and elderly (66 years old in 2000).

Participant Observation

One suggestion for fixing health care problems is mandating employer based coverage. Hawaii does just that and it has the lowest health insurance premiums in the country. It also has a state subsidy for persons who are unemployed and low income. As expected the coverage is offered through managed care and preferred provider organizations. However, it does not work for every one.

At present I am resident scholar at the Center on Disability Studies at the University of Hawaii at Manoa. The Center is an umbrella organization for some 30 programs including the Hawaiian University Affiliated Program, the NIDRR funded National Center for the Study of Postsecondary Educational Supports, the Maternal and Child Health Program on Leadership Education in Neurological Disabilities, the Pacific Partnerships in Disability and Diversity Studies, and a number of other projects. I am affiliated in various ways with each of the named programs. I am also affiliated with the Department of Urban and Regional Planning and the Department of Pediatrics, John A. Burns School of Medicine, both at the University of Hawaii at Manoa. However, the terms of my affiliation with these programs does not include health insurance.

Before coming to Hawaii I was a member of a managed care plan for 27 years, the Harvard Community Health Plan which is now named the Harvard Pilgrim Health Plan. When I informed Harvard Pilgrim Health Plan that I was moving to Hawaii (outside of their coverage area) they told me that after three months I would be dropped from their membership rolls. The university at which I previously taught transferred me to a preferred provider organization (PPO) which is a part of, but separate from, HPHP. That university will pay half of the PPO premiums for the rest of my life. Understandably I have kept this coverage.

Once in Hawaii I began contacting physicians in order to choose a primary care physician. Every one I contacted either said that they were not taking any new patients (the nice reason) or that they simply would not deal with out of state health insurance. I might have eventually found a primary care physician, but a search for over four months had not turned one up. This result is an unintended outcome of mandating employer based health insurance coverage. Either the physicians do not need additional patients or else they do not need them badly enough to deal with an out of state PPO.

When I needed medical attention I went to the Waikiki Health Center which is near my home. It is the local neighborhood health center supported by the United Way, some Waikiki hotels, other corporations, some state tax funds, and individual contributions. It is for the homeless, for persons with low incomes, for tourists, and for rich white males (like myself) who have out of state health insurance. It was a pleasant experience and I received excellent care. It is now my health provider of choice.

It is somewhat ironic that one of the states which is singled out for an excellent solution to providing health coverage for all, could not deal with my need. It is fortunate that I lived close to the neighborhood health center and went there for (in effect) emergency care since I could not find a physician who would see me.

Survey Data

In Pfeiffer et al. (1997) people with disabilities in Massachusetts were surveyed about managed care and fee for service plans. It has a sample size of 258 persons. The mean age of the respondents was 48 with a standard deviation of 13.7 and a range of 13-94. There was one 13 year old and three 14 year olds. Five persons were in the 20 to 25 year old range and all the rest were older. Thirty one were 65 and older with 14 in their 70s, one 80 year old, and one 94 year old. The sample was evenly divided between men and women.

Of the respondents 32% were in managed care, 63% were in fee for service, and 5% had no health insurance. When asked to rate their health insurance plan 23% said excellent, 58% said good or very good, 15% said fair, and 4% said poor. Generally they liked their plans.

When I reanalyzed the data I found that the correlation (Pearson's r) between age and rating of the plan was not statistically significant. I then divided the respondents on the basis of age into two categories: 13 to 59 and 60 to 94. I also divided them on the basis of the rating of the health insurance plan into two categories: positive (excellent, very good, good) and negative (fair, poor).

Three crosstabulations of the dichotomized age and rating variables were run: the entire sample, managed care only, and fee for service only. The results for all three groups were random. There was no statistically significant relationship between age and how they rated their health insurance.

Since the ratings of the health insurance plans were more positive than negative, I concluded that in Massachusetts older people generally and persons 60 and on up compared to 59 and under do not differ in their evaluation of health care plans. If they are in managed care they mostly like it. If they are in a fee for service plan they mostly like it. (It was assumed that some of the persons 62 to 64 in age and all persons 65 and over were in Medicare which could be managed care or fee for service.) Since those persons without health insurance had no plan to rate, they were excluded.

Health Care and Elderly People

However, there are many questions being raised about how elderly people are being treated by their health care plans, especially managed care plans. In addition there are specific problems with Medicare such as an insufficient prescription drug plan. In order to draw some conclusions we must clarify the role of elderly people in our society.

One answer to the question of what is the role of elderly people in our society is that we are conservators of the past and teachers of the young. That is not accurate.1 Anyone who approaches this topic or any topic relating to elderly people with such a paradigm of aging is devaluing them because we simply do not function in that way, we are not expected to function in that way, and we do not want to function in that way. It is the same as viewing people with disabilities as courageous. That is also not accurate. In other words health care is not to be provided to elderly persons because they are conservators of the past and teachers of the young.

On what basis and for what reason should elderly persons be provided good health care? Should we provide health care only to elderly people who have a high quality of life (QOL) and thus can benefit from continued living? I have a very high QOL, but many people deny it and pity me. "High" by whose standards?

There is a great similarity between people with disabilities and elderly people: we both face discrimination and denial of equality on the basis of artificial, unnecessary barriers based upon prejudicial attitudes toward us. To many people (elderly and otherwise) I represent death in my wheelchair because just before you die you go into a wheelchair. They saw their parents or grandparents or friends become ill, start using a wheelchair, and then die. I have seen looks of horror from many persons. One of the biggest barrier to us (elderly and disabled) is the stereotype of "normal." It is these stereotypes which cause the problems in health care delivery.

On what basis, then, should health care be provided? There are some commonly proposed values to govern health care provision: fair access, efficiency, quality of care, respect for patients, and choice. No one opposes these values! Their discussion is meaningless. The whole

question revolves around who gets to benefit from the provision of health care. There is NO ethical, moral, just way to ration health care. Whomever has the power and can work the system will receive health care now and in the future. The solution is political: what process guarantees equal protection and due process, parity in the provision of services? (No one seems to have proposed rationing health care on the basis of power. I just did.)

We have to look at the provision of services (health care and other services) as investments in people - elderly people and people with disabilities. We have to view it as a right (equal protection and due process to produce parity). Measurements of quality of life or healthy life years are rationalizations for the powerful continuing to receive services while the rest are denied. All elderly people and people with disabilities are asking is parity with other persons - such as professional athletes, clergy, physicians, politicians, bankers, stock brokers, professors and the list can go on of people who have a privileged place in society. And if we have to get this parity through political power we will - and we are now seeking to do it.

This essay is based on a presentation at the November 1997 meeting of the American Public Health Association as part of a panel organized by David Keer. Participants also included Kate Seelman, Pearl German, and Larry Branch.

Endnote

1. In my panel presentation I used a term which is not a polite one.

References

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