BABY BOOMERS CAN MY EIGHTIES BE LIKE MY FIFTIES? (SPRINGER SERIES ON LIFE STYLES AND ISSUES IN AGING) pdf

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Baby Boomers|Is the United States prepared for the Baby Boomers to grow old? This book seeks to answer these questions.

Canadian National Population Health Survey â€" Population Sample of 10 individuals aged 20â€"69 years in â€" and who were from 5 birth cohorts: Generation X Gen X; born: Main outcomes Use of primary care and specialist services. Results Although the overall pattern suggested less use of physician services by each successive recent cohort, this blinded differences in primary and specialist care use by cohort. Multilevel analyses comparing cohorts showed that Gen Xers and younger boomers, particularly those with multimorbidity, were less likely to use primary care than earlier cohorts. In contrast, specialist use was higher in recent cohorts, with Gen Xers having the highest specialist use. These increases were explained by the increasing levels of multimorbidity. Education, income, having a regular source of care, sedentary lifestyle and obesity were significantly associated with physician services use, but only partially contributed to cohort differences. Conclusions The findings suggest a shift from primary care to specialist care among recent cohorts, particularly for those with multimorbidity. This is of concern given policies to promote primary care services to prevent and manage chronic conditions. There is a need for policies to address important generational differences in healthcare preferences and the balance between primary and specialty care to ensure integration and coordination of healthcare delivery. Large longitudinal data, spanning 18 years, enabled us to compare different cohorts at the same chronological age. Our analytical methodology integrated changes in healthcare use indicators with changes in factors associated with them. The interpretation of the findings is limited due to the inability to identify the specific conditions for which individuals are consulting with physicians. The data are self-reported and the bias associated with inaccuracies and reporting errors is unknown. Introduction Older age is typically associated with worse health, higher healthcare use 1â€"3 and increased healthcare costs. Two issues have been raised: On one hand, these advances have the potential to improve the health of boomers and reduce their need for healthcare services. On the other hand, these advantages have also contributed to longer life expectancy and improvements in survival. As a result, people are living longer with the potential of developing multiple chronic conditions and hence needing more healthcare services. This consumer market has positioned health as an individual right, and as a result, many people have proactive behaviours towards their health decisions and selection of services. Studies have not investigated whether there are generational differences in healthcare use, including consultations with primary physicians and specialists. Formulating policy changes and interventions to accommodate the needs of this large cohort will require a thorough understanding of these patterns and the diverse factors affecting healthcare use in boomers and other cohorts. Behaviour-related risk factors eg, obesity can also be included in the framework. Previous research has found cohort differences related to a number of factors relevant to healthcare use of baby boomers and other cohorts. For example, improvements in the standard of living and education attainment since the s 24 25 might be expected to reduce the need for healthcare among baby boomers and succeeding generations. Declines in smoking rates in recent cohorts 26â€"28 are also likely to be related to better health and reduced healthcare. An Australian study found that Generation X Gen Xers reported more diabetes than baby boomers 34 and a study from the UK 37 found that boomers had more hypertension and diabetes than their predecessors. In contrast, a study of US women found no differences in arthritis prevalence between baby boomers and the previous generation. The overall goal was to 1 compare primary care and specialist services use over the lifecourse across birth cohorts and 2 to examine cohort differences in predisposing, enabling, need and behaviour-related risk factors that could explain cohort differences in the lifecourse trajectories of primary care and specialist use. The NPHS retained individuals who moved to long-term care institutions and those who died over the course of the survey. This resulted in a sample of 10 individuals with an average of seven cycles of data. The University of Toronto Ethics Committee

approved the study. Data sharing The survey is not publicly available and authorisation from Statistics Canada is required to access the data. Therefore, there are no additional data available. Primary outcomes At each cycle, participants were asked about their use of healthcare in the previous 12 months. Canada has a national healthcare policy which provides universal coverage for all medically necessary hospital and physician services with no copayments or other patient charges. Furthermore, specialists like those in general internal medicine do not have primary care roles in Canada. Predictors Cohort membership and age were based on year of birth. Participants were allocated in five birth cohorts: Education was measured as years of schooling and was grouped for analyses as: Enabling factors were household income and having a regular source of care. Household income was collected at each cycle and categorised into quartiles of the distribution at each survey year with a separate category representing missing values. We used the presence of chronic conditions as an indicator of need for care. The number of chronic conditions was grouped as: We also examined behaviour-related factors: Participants were grouped as: We grouped body mass index as: Responses were used to group individuals as physically active during leisure time or active commuting versus inactive based on Statistics Canada-derived variables. Statistical analysis Comparing birth cohorts is complex because cohort differences are linked to the effects of ageing as well as societal and environmental changes affecting the population as a whole period effects. Therefore, in addition to age, it is pertinent to consider period effects eg, survey year , as these may obscure cohort effects unless they are properly modelled. However, studies aiming to estimate the effects of age, period and cohort are hindered by the identification problem; that is, age, period and cohort are linearly dependent. As a result, they cannot be modelled at once. One way to deal with this problem is to directly estimate age and cohort effects as fixed effects while accounting for variability across periods random effect see discussion in Bell 41 and Suzuki To do this, we fitted cross-classified multilevel models in which observations were nested within individuals and individuals were nested within time periods. We started with a model with age and cohort model 1. In the next steps, we added predisposing, enabling and behaviour-related factors model 2. And finally, we added need factors model 3 and examined variations in the age and cohort estimates. In all models, age was centred at 39 years the mean of the distribution for the five cohorts at baseline â€” The significance of variables was assessed by Wald tests. Supplementary analyses We conducted three sets of supplementary analyses. Second, using the number of chronic conditions as a global measure of need for care precluded us from elucidating the effects of individual chronic conditions in explaining cohort differences in the outcomes. Therefore, we repeated the analysis 17 times by adding each individual chronic condition to the models and examined changes in the cohort coefficients. Finally, we examined the impact of attrition in our analyses by comparing the results of the models including indicator variables identifying participants who dropped out or died before the end of the study and the results of restricting the analyses to individuals with complete data in the nine cycles. Patient involvement This study is based on a population survey that did not involve patients. Results Descriptive In â€”, there were 10 participants who met the inclusion criteria: Generally, physician services use was higher in women than men overall and for primary care and specialist use table 1. Women reported having a regular source of care more often than men in all cohorts, with the exception of the pre-World War II cohort. Education was higher for younger boomers and Gen Xers, while older boomers had the highest income. Men reported slightly higher household income than women in all cohorts. Dropping out of the study was the most common source of attrition among baby boomers and Gen Xers and death in the pre-World War II cohort table 1. In preliminary analyses, we found significant differences in the outcomes and predictors by gender; therefore, results are presented for women and men separately.

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