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New Federalism and Long-Term Care of the Elderly
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New Federalism and Long-Term Health Care

President Reagan’s New Federalism proposals have raised profound and complex questions in many domestic social program areas, but none more difficult than those involved in providing long-term health care for the elderly. Despite a failure to generate great support even from state or local governments for its specific proposals, the Reagan administration continues to place a top priority on a reshuffling of federal, state, and local responsibilities. Responding to widespread confusion over the actual details of the proposals themselves and to a great deal of both anxiety and hope regarding their impact, the Project HOPE Center for Health Information convened a conference at the Project HOPE Health Sciences Education Center in Millwood, Virginia to analyze the meaning and implications of the New Federalism proposals for long-term health care policy. The conferees were asked to focus on three basic issues: (1) the criteria that might be used to determine the respective roles of the different levels of government in the provision of long-term care; (2) the likely shape of long-term care in the foreseeable future; and (3) the probable impacts of anticipated policies and programs on the elderly and on providers of long-term care.

The conference brought together a wide variety of disciplines and interests, including government officials from the federal, state, and local levels, representatives of provider organizations, academics with a special interest in health care, members of the health professions, and consultants in the field. Over a period of a day and a half, some six separate sessions were held, at which five papers were presented, each followed by several commentators and a general discussion. Though a number of
common threads and themes developed during the conference, there was no attempt to put together a unified statement or consensus document. Rather, Project HOPE viewed this conference as the first of several that are needed in order to resolve the issues surrounding New Federalism and health care of the elderly.

**Definition And Timing Problems**

Both New Federalism as a fact, concept, and current policy and practice in the area of long-term health care present particularly difficult problems of analysis at this time. The conference participants were faced with moving targets in terms of definitions currently in use, the implications of trends already in motion, and the likely results of policy changes contemplated or recently put in place.

Moderator Neil Peirce of the *Nation Journal*, Director of the Center for Health Information, and Professor Benjamin Barber of Rutgers University each sought to give more clarity to the Reagan administration's New Federalism proposals by placing them in an historical context. In a elegantly crafted after-dinner address, Professor Barber traced the continuing debate and dialogue over federalism from its origins at the founding of the republic through the nineteenth and into the twentieth century. He argued that each generation redefines federalism in light of its own needs and problems, and noted that there has never been one model for a proper division of authority among the federal, state, and local governments. To Barber, it is the existence of the debate itself, rather than its components at any given moment, that is important. Thus, he concluded: “In the final analysis, history shows that liberty has been best served in our unique system neither by the nationalist nor the sectional interpretation of federalism, but by the argument itself. If this is so, we should not fear argument but welcome it-and be glad that our republic still resounds with the clamor of women and men arguing over the meaning of their Constitution. That clamor is the life breath of the republic . . . .”

Neil Peirce contrasted the Reagan variation of New Federalism with the quite different version that had been espoused by the Nixon administration, and John Crosby identified the intellectual origins of Reagan New Federalism in ideas David Stockman was espousing in the mid-1970s. Stockman, as early as 1975, in reaction to what he considered the debilitating effects of single-interest politics, called for sweeping reforms in national social programs, major consolidations of numerous categorical programs, and shifting many responsibilities back to state and local governments. The Reagan administration’s initial proposal carried through the main goals of Stockman’s 1975 recommendations, (the major exception being income security which Stockman proposed to
Thus, the president recommended that the federal government assume full control of Medicaid and turn over to the states funding responsibility for food stamps and AFDC (Aid to Families with Dependent Children). In addition, over the next several years, the federal government would turn over to the states some forty categorical aid programs in various domestic program areas. Initially, a trust fund would be created to finance these programs, but it would be phased out by 1991. In response to demands by state officials, the administration has made one major change in the year since the program was announced: it has agreed that food stamps will remain a federal responsibility. But the administration and state and local government officials remain far apart on the question of transferring other income security programs to the states.

Beyond the confusion engendered by changes in key components of the New Federalism package on a symbolic level, as Neil Peirce and others pointed out, there is also great division of opinion about the real meaning of the reform. To some, it represents a “social cop out;” to others, a “timely and essential decentralization” after decades of overloading the federal government with responsibilities it was ill-equipped to handle. A further complication revolves around the fact that along with major federalism proposals came proposals for substantial budget reductions in numerous domestic program areas. Though the issues presented by the two sets of policies were actually separate, inevitably New Federalism had become increasingly identified with social retrenchment.

In the area of long-term health care, the difficulties are compounded because even a year after the original federalism package was unveiled, the administration has made no decision on its placement in the federal scheme. At the time of the conference, according to John Crosby, the current prediction was that the administration would propose separating long-term care from Medicaid and handling it through a block grant to the states. Alternatively, the governors had suggested splitting Medicaid into three categories: acute care for SSI recipients; acute care for AFDC recipients; and long-term care for the aged, blind, and disabled. The governors offered to swap responsibilities with the federal government for any one of these categories or a combination thereof, although in their proposal they were clearly the least enthusiastic about the federal government assuming the responsibility for long-term care.

Meanwhile, at the state level, in response to steeply rising costs and new federal flexibility, there is evolving an extraordinary new array of approaches and programs designed to cut costs and provide more effective health care delivery. Many of these programs are quite recent; some already show great promise but the ferment and pace of change further complicates the task of the policy analyst and the political leader in attempting to come up with an optimum mix of federal and state responsibilities.
A major vehicle for state exploration of new approaches is the provision of the Budget Reconciliation Act of 1981 that allows federal regulators to grant waivers for states to experiment with cost-containment innovations in their Medicaid programs. At present, forty-four requests have been received for such waivers, and twenty-four have been granted by the Department of Health and Human Services (DHHS). In his paper, Larry Bartlett gave a detailed accounting of many of the innovative programs being planned and implemented by the states. According to Bartlett, the states were moving in three broad areas to control the costs of long-term care: (1) utilizing alternative methods of paying providers such as “capitation payments” and having the state act as a “prudent purchaser” of various laboratory services and medical devices; (2) instituting “gatekeeping” mechanisms to restrict access to institutionalized service; and (3) targeting community-based care only to high-risk individuals through client and case management programs.

While activity is proliferating, said Bartlett, the states are at the same time to some degree held back from venturing even further and faster by two factors: a lack of consensus about how best to care for the elderly, and a fear that during a time of extreme budget constraints some new approaches would not be cost effective and indeed would generate more demand on public resources. Stated Bartlett: “There is no generally accepted view that all, or even most, states share about how the elderly should be cared for. While there may be a general feeling that people should not be unnecessarily institutionalized, many states have indicated that they have no idea of which specific services prevent institutionalization, nor do they know whether or not such a program can be cost effective. Almost uniformly, discussion with state officials revealed that interest exists in developing community services for the elderly, but the service system is not well conceptualized.”

Thus, recapitulating, it was against a background of a great deal of movement at the state level and a great deal of confusion at the federal level that the Project HOPE conference on New Federalism and long-term health care convened.

## Dividing Responsibility For Long-Term Care

Jule Sugarman, Executive Director of the Human Services Forum, contributed perhaps the most detailed thought on potential criteria for dividing federal, state, and local responsibilities for health care of the elderly. Sugarman expressed opposition to much of the thrust and direction of the Reagan New Federalism, labeling the original proposal as one for the “federal government to abandon responsibility for human services.” The “name of the game,” argued Sugarman, “was not New Federalism but New Individualism. By that I mean to say that I think that what we are
now seeing is not so much an issue of how to allocate responsibilities between government and people. I think in fact that whether by design or by circumstances we are moving into a very basic issue of what the government will be responsible for.”

Starting with the New Deal, Sugarman traced the history of the assumption by the government, through use of the public taxing system, of activities and responsibilities that had traditionally been born by individual and families. More recently, a reaction against the level of taxation and the quality of services gained from public taxation - have produced a “schizophrenia” in which the public wants both to reduce taxes and to retain what it has come to consider essential services.

While clearly opposed to the degree of social retrenchment he perceived as intrinsic to the administration’s proposals, Sugarman tailored his own recommendations regarding long-term health care to an assumption of the “reality . . . that we are in deep fiscal trouble in this country,” and “there may well not be the resources available to do the kinds of things we should like to do.”

Acceptance of this “reality” led him to propose a more limited - though still substantial - role for the federal government: that is, of establishing and financing a “national floor” for long-term health care. The federal government, thus, would limit its responsibilities to those services which were “essential rather than-as it had often attempted to do in the past - also lead the way in underwriting those services which were “desirable” or “optimal.” Such “enhancements” above the floor should be the responsibility of the states or the private sector. (Sugarman also argued that long-term care costs should not be passed to local governments, though cities and counties might well administer programs.)

Finally, Sugarman emphasized, and others seemed to agree, that the federal government does have a unique capability to act as a catalyst for the states through the funding of research and demonstration programs, and as a central communicator by supporting national reporting systems, data collection, publications, conferences, and exchanges of personnel.

Richard Hodes, former president of the National Conference of State Legislatures, followed Sugarman and addressed in more detail a point Sugarman had raised, that is, the necessity of devising more equitable methods of calculating the fiscal and tax capacities of individual states. Both speakers stressed the need to equalize the base level of support for citizens regardless of happenst ance of residency. Sugarman suggested that a block grant, skewed toward lower-income states, might be a solution. Hodes contended that the formulas developed by the Advisory Commission on Intergovernmental Relations to measure the actual tax capacity of a state would be much preferable. He pointed out that distribution based only on per capita income could produce inequities; Louisiana and
Florida, for instance, though they ranked below a number of states on this basis, have other large resources to tap: energy, in the case of Louisiana, and tourists (through sales taxes) in the case of Florida. Other states have no such recourse. Both Sugarman and Hodes, then, foresaw that as an adjunct to establishing a national floor, the federal government would be drawn into assuming the role of equalizer among states.

Specific Recommendations For Reform

In contrast to Sugarman and Hodes who adopted broad national approaches and then applied those national precepts to long-term health care, Anne Somers concentrated the bulk of her attention and analysis on the current details and realities of the long-term health care system and built recommendations for changes in national policy on this foundation.

Somers posited four major programmatic guidelines for reform of long-term health care programs. The first and overriding goal was maximum functional independence; second, there should be continuity in the treatment or management of chronic illness; third, well-delivered long-term care needs a creative blend of medical and social services, organizationally and professionally; and fourth, there should be an unbiased availability of both institutional and noninstitutional care.

Somers surveyed existing long-term care programs in light of these guidelines and found them “egregiously deficient.” Medicare, for instance, focuses almost entirely on short-term acute care, and prohibits the payments of “custodial” care, under which most of the necessary skills for chronic care would be grouped. The Medicare message for the seriously ill patient, argued Somers, is “Get well fast, die, or get lost!” Only in the field of home health care have recent changes signaled sensitivity to the needs of the chronically ill. Beginning in 1981, home health benefits were liberalized and restrictions on them eased.

Sixteen percent of the Medicaid population is over sixty-five, but this group accounts for almost 40 percent of the cost. Most of the money going to the elderly in Medicaid is primarily for nursing home care for those who have been forced to “spend down” to the penury level in order to qualify for the benefits. Even though Medicaid now carries a lot of the burden for elderly long-term health care, it represents a flawed and inconstant solution to the problem, according to Somers. First, it covers only the very poor approximately 13 percent of the total elderly population. Second, there is the instability caused by the welfare nature of the program. Long-range planning is not possible for either providers (nursing homes) or the recipients. Third, fragmentation of the elderly patient between Medicare and Medicaid inevitably renders continuity of care difficult, if not impossible. Fourth, and most important, there is a basic conflict between the attributes of a welfare program such as Medi-
caid and a central goal of long-term care - maximum functional independence. Since eligibility is limited to those both financially and medically dependent, both types of dependency are promoted. Middle-class families, for instance, must first almost totally deplete their resources in order to qualify as "medically needy."

Somers reviewed three broad policy options to reform the current flawed federal programs for long-term health care for the elderly: add long-term care benefits to the existing Medicare program; continue Medi-caid as the primary long-term health care program, either on the present federal/state grant-in-aid basis or by changing it to a block grant program; or devise some creative compromise between the first and second options. After reviewing the pros and cons of each of the options, Somers recommended that the best approach would be a creative blend of Medicare and Medicaid, including the establishment of a new federal/state/community long-term health services coordinating program under the aegis of the Department of Health and Human Services (DHHS).

As the first part of the blend, Somers recommended that Medicare rules should be extended to include provision for long-term care through eliminating the prohibition for custodial care and through the addition of a schedule of benefits for both institutional and home-based long-term care for the elderly. Financing for the new benefits would come from reprogramming existing funds and from new sources, including transfer of Medicaid funds currently targeted for long-term care to Medicare; user fees and cost-sharing formulas for routine long-term benefits; additional cost-sharing for very expensive care; and prospective payment of Medicare providers through periodic negotiations.

The second part of Somers's proposals consisted of the creation of a new federal/state/community program to coordinate long-term care. A federal office in DHHS would provide guidelines for community-based organizations that would function as coordinators of the case managers of long-term individual patients through providing initial comprehensive assessment of needs, appropriate placement, followup, and monitoring. The responsible physician or group, as well as the family and patient, would continue to play leading roles in the decision-making process.

Views From The Reagan Administration

Three speakers presented the views of the Reagan administration regarding the place of long-term health care policy in the overall goals of New Federalism: Robert Rubin, Assistant Secretary for Planning and Evaluation, DHHS; F. Lynn May of the Health Care Financing Administration, DHHS; and Dr. Samuel Lin, Deputy Assistant Secretary for Health, DHHS. Because the Reagan administration was still in the process of formulating specific proposals regarding long-term health care policy,
its spokesman could not give exact details; rather, for the most part, they attempted to lay out the guiding principles from which policy will later emerge.

Dr. Rubin opened his remarks by stating that “long-term care for the elderly . . . has emerged as one of the most important social policy questions of the 1980s.” Looking ahead, he saw both positive trends and difficult challenges. Among the positive trends, he listed the fact that more elderly are retiring with greater financial security through Social Security and private pensions, and that biomedical advances are producing a healthier elderly population-less that 5 percent of the elderly are in long-term care institutions at any given time.

At the same time, enormous pressures are being created for the elderly health care system by the dramatic rise projected of the number of Americans over sixty-five, and by the huge increases in national expenditures for health care for this element of the population. For instance, nursing home care expenditures more than doubled between 1976 and 1982, from $11.4 billion to $24.2 billion. The Reagan administration, he stated, was seeking an “effective response” to these challenges. In crafting such a response, four policy principles or considerations would serve as guidelines.

First, federal policy should aim to preserve the maximum flexibility in the organization and provision of long-term health care. Noninstitutional as well as institutional care should be accommodated and the diversity of state and local needs and priorities should be encompassed. Rubin cited the waivers allowed in the 1981 Budget Reconciliation Act as examples of the Reagan administration’s attempts to promote flexibility.

Second, public policy should “encourage and reinforce the central roles of families in caring for the elderly.” The primary responsibility for such elderly care should be rooted in the family, with the government providing aid that will allow families to keep the elderly with them through such measures as respite care and the provision of case management assistance.

Third, public dollars must be targeted to those with the greatest need and fewest resources. Rubin acknowledged that targeting was a difficult and complex task, but he argued that the limitation of public and private resources made such discipline an imperative for policymakers. He cited income and lack of an adequate support system (family) as criteria for need. State screening programs would have to be utilized more frequently in the future, he said.

Fourth, public policy should encourage the private sector to assume a greater role in the financing of long-term care. He noted that some businesses were looking at expansion of pension plans to include chronic care for the elderly, and private long-term coverage is being examined by insurance companies. Federal policy should move to facilitate intergov-
ernmental and public and private cooperation in the provision of new private coverage and markets.

Rubin cited several other positive trends to alleviate the growing problems of financing and administering long-term health care. These included: the increased provision of reverse equity mortgages whereby elderly owners receive monthly payments from financial institutions in exchange for equity in their houses; modification of local zoning laws to allow expansion of group housing arrangement for the elderly; and the growth of ombudsman and advocacy services for elderly who reside in nursing and boarding homes. He argued, finally, that there was no single bold stroke or one program that would solve the problems associated with long-term health care for the elderly. It is the administration’s belief and strategy to plan and execute policies for incremental change in the financing and administering of health care for the elderly.

Dr. Lin, as did a number of speakers, described first the most important demographic and social forces that would exert an impact on health care policy for the elderly in the coming years. From this base, he suggested a number of changes that would be necessary in both the medical and social approaches to the well-being of the elderly. He called first for a reorientation away from the traditional curative or reparative attitude toward medicine and a new emphasis on the prevention of disease and disability and the promotion of good health. As examples, he cited the need for greater education regarding the effects of smoking, the need to continue to stress the positive benefits of physical fitness, and the need to provide good nutrition for the elderly and make them aware of the necessity of adjusting their diets to their bodies’ changing digestive abilities. Finally, Lin affirmed that the Reagan administration was committed to strong support of one major role of the federal government: funding and commissioning biomedical and behavioral research relating to the health problems of the elderly.

F. Lynn May stressed the administration’s commitment to providing creative means of fulfilling the concept of a continuum of care. He stated that its encouragement of the waivers for states under Medicaid, its current effort to develop a proposal for paying for skilled nursing facilities on a prospective basis, its support for hospice programs, all represented tactics to explore and fill out the continuum.

Recurrent Issues In The Discussion

During the course of the day-and-a-half conference, the discussion among the participants ranged over a wide variety of issues and questions, some of which stemmed directly from points made in the papers and talks and some of which cut across or went beyond the paper topics. What follows is a representative sample of the line of debate regarding
some of these questions.

1. Block Grant for Long-term Health Care

There was some division of opinion over the merits of the federal government providing aid to the states in the form of a block grant for long-term care for the elderly. (The issue was also clouded by a lack of clear knowledge regarding the nature and coverage of any proposed block grant.) Anne Somers argued against a block grant that was limited only to long-term care, stating that such a split would further isolate long-term care from the mainstream of health care and, by removing state responsibility for acute care, would remove incentives for them to minimize health and hospital costs for these patients.

Other participants were more supportive of the block grant approach, though not necessarily the specific administration proposal. Helen O'Bannon, Secretary, Pennsylvania Department of Public Welfare, noted that the block grant did offer the states the possibility of designing more flexibility into their programs and not having to tailor their programs to rigid federal requirements that did not meet all of their needs. Similarly, Richard Curtis of the National Governors Association, and Beverlee Myers, Director of the California State Department of Health Services, pointed out as Bartlett's paper documented exhaustively—that the states were acting creatively to explore a variety of cost-effective and equitable long-term health care delivery systems. Both, while not defending the administration's specific proposals, did make the case for a system diverse enough to include minimum national standards and substantial flexibility for state variations.

Janet Smith, Director of Legislative Development and Analysis, New York City Health and Hospitals Corporation, also discussed in one of the papers presented the need for a block grant approach that is flexible but that contains certain minimum safeguards. After outlining the necessary criteria to serve as a basis for a block grant, she discussed two types of approaches that could be considered: (1) an entitlement program in which funds are provided to states for a range of community-based services, or (2) a more limited block grant which provides additional funding for the expressed purpose of establishing alternatives to institutional long-term care services.

Ms. Smith expressed dissatisfaction with previous federal and state experiences utilizing block grants, tracing the nation's past experience with such programs as "314 (d)." She expressed the concerns of big city mayors and urban county officials, the most fundamental of which is "not the mechanism [that] is chosen to distribute the funds, but the amount that is available to be distributed." She concluded that the block grant approach "could play a very valuable role in the development of long-term care options," pointing out that the willingness of local officials to support the block grant concept stemmed from their belief that no one approach
is the answer. Instead, what is needed, she maintained, is a variety of solutions to meet a wide range of local public needs.

2. Medical vs. Social or Other Models

There was a great deal of discussion about the most relevant and effective model to adopt philosophically for long-term health care. Various discussants noted that federal programs had been constructed from too narrow a view of the problem, a view that centered on short-term acute care in an institutionalized setting. There was general agreement that the move toward a “continuum of care” should be accompanied by a broader view of the support services necessary for the total well-being of the elderly recipient. Other skills—nursing, custodial, case management, and the fostering of social and interpersonal activity—would need to be factored in the future.

3. Costs/Resources Targeting

The problem of costs loomed very large in a time of recession and the prospect of extremely limited public resources for the foreseeable future. It was this reality that caused Sugarman to revise downward his view of the role of the federal government to one of providing minimum essentials; and Somers, though she argued for universal long-term health care as an entitlement, ultimately suggested that initially those over seventy or seventy-five should be given priority. While they might disagree on the criteria, most participants seem to have agreed with the strong call by Reagan administration officials for future targeting of public funds to those most in need.

4. Innovation vs. Demand Creation

Many of the most innovative state and local programs for long-term care for the elderly move in the direction of noninstitutional settings that provide support services both short of, and in addition to, the traditional medical services funded by current government programs. While there was near-unanimous approval of this trend, a number of participants expressed concern that it would quickly increase pressures on public resources. Noting that currently 60 to 80 percent of all long-term care is provided on an informal, unpaid basis by relatives and friends, one participant pointed out that “a Lot of folks are very nervous,” because they may have created “a very large, costly market . . . . How do you address the sociological phenomenon that once you put money out there you suddenly change the nature [and demand for the program].” And another commentator added: “The minute you finance a service, that is where all the consumption is Going . . . . I think that is very rough, but I think it is something worth a little bit more exploration than I have seen taking place.”

5. Individual Choice and Freedom vs. Budget Control

Participants as diverse as Robert Rubin and Jule Sugarman agreed that maximizing individual choice in regards to the type and form of
care should constitute a major goal of long-term care policy. Several participants, notably John Grana and Burton Dunlop of Project HOPE, suggested that a significant portion of the elderly population might benefit by a move toward cash grants which would allow them to exercise their own judgment as sophisticated consumers. Others, however, without addressing this proposal head on or recognizing that a cash grant could be set at a level equal to or less than current average recipient costs for services, pointed to a potential clash between budgetary constraints and the goal of maximizing individual choice. Washington attorney Frank Samuel stated that in his opinion: “Budget control means that the talk about maximizing individual choice is all talk . . . . I do not agree with Jule Sugarman and Bob Rubin that what we are going to be able to see is maximization of choice; quite the contrary, if we are going to achieve cost reduction, particularly in long-term care, we are going to have to utilize the gatekeeping and assessment mechanism not only as a kind of theoretical procedure [but] we are going to have to take the next step of denying a long-term care bed to somebody who doesn’t need it whether or not they can pay for it themselves . . . .”

Helen O’Bannon suggested that what might well emerge was a two-tier or two-class system. For the middle-class, there were a number of possibilities for choice of program and support mechanisms, ranging from vouchers to Medicare and private insurance. For a second class, the poor and the disabled, however, there would be much less choice because the support dollars would have to come from increasingly strained federal coffers. Thus, she concluded: “The paradox is [that] you will have a buyer-driven system for the middle class and a government-choice system for the poor and disabled.” In devising programs for both classes, moreover, ultimately “cost is the very real bottom line problem.” For this reason, like Frank Samuel, O’Bannon was skeptical of expansionary hopes for universal entitlement or maximization of choice, although her focus clearly centered on services rather than other alternative mechanisms such as a cash disability allotment designed to maximize recipient choice.

Summary

Neil Peirce closed the conference with a summary that combined his own commentary on several of the most significant issues with a review of the highlights of the discussion.

In the first place, Peirce felt that, contrary to the assumptions of some of the participants, the fiscal situation would likely get a good deal worse before it got better. For the foreseeable future this would mean a continuing downward pressure on public resources and programs. “At a time of national fiscal emergency, I can’t imagine the political process saying, ‘Yes, we will increase our obligation of the scope of our role in the health care
area for long-term care or any other area of medicine,’ ” he said.

Regarding the larger issues presented by Reagan New Federalism, he noted that whatever one thought about the specifics, the problem of sorting out responsibilities predated the Reagan administration and had been a concern of liberals as well as conservatives. There was a common feeling that the federal government had grown too large both in terms of dollars and the span of program control.

The field of long-term care presented a case study for working out a new synthesis for federalism. Peirce concluded that there needed to be national standards and a national minimum, but along with this the federal government would also have to assume the responsibility for equalizing the very disparate ability of individuals and states to shoulder their part of the burden. He applauded the kind of tax capacity formulas devised by the Advisory Commission on Intergovernmental Relations, and expressed support for the national state equalization trust fund suggested by Senator David Durenberger (R-Minn.)

Peirce expressed the belief that the states had come a long way over the past decade and stood ready to assume a sizable administrative responsibility for the provision of long-term health care. Further, he argued that there was substantial evidence of an “immense outpouring of civic activism” at the local and state levels around the country. Local communities today, through public and volunteer organizations, were much better able to cope with problems of the elderly, or a myriad of other social problems. Finally, however, he echoed Dr. William Walsh of Project Hope, when he affirmed the necessity of a more “cooperative society and a recognition between various groups of what the needs of others are.” The key question finally, for Peirce, became: “How can we activate a new spirit of public/private cooperation in coping with a deep and ongoing and national problem, . . . [This] is also one of the major human opportunities of our time, and that is why I think [the Project Hope conference] is relevant.”

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