Prologue: The increasing number of elderly people in the U.S. population poses a variety of public policy challenges. Not the least among them is the implementation of a strategy that provides long-term care in a cost-effective manner that is sensitive to the medical and social needs of older Americans. Answers to these questions will not come easily. Indeed, the Reagan administration and Congress chose to essentially ignore them as they moved to approve a new Medicare benefit that will provide elderly beneficiaries greater protection against the economic consequences of acute illness. The one essential reason for this failing? Long-term care benefits are too expensive and their projected future cost too difficult to predict. In this essay, sociologist David Mechanic outlines a strategy for long-term care that supports community participation and reinforces the informal care and support that already exist. It stresses that Medicaid should include protection against catastrophic illness but that this is only part of the solution. A strategy of long-term care is required that makes it possible for the elderly to obtain care without first becoming destitute. Overall, the challenge of long-term care is to develop a viable financing structure that is within a meaningful community context and consistent with efforts to sustain voluntary long-term care efforts. Mechanic is director of the institute for Health, Health Care Policy, and Aging Research at Rutgers University, where he formerly served as dean of the Faculty of Arts and Sciences. An active member of the National Academy of Sciences’ Institute of Medicine, Mechanic is the author of numerous books and articles, including three previous papers in Health Affairs.
The health care arena is in extraordinary ferment. The traditional structures that have defined medical practice, such as the hospital and solo physician practice, are undergoing major transformations, but the shape of future organization is still in an early stage of evolution. The realignments now taking place are experienced as major dislocations by providers and managers of existing services, but there is little reason to anticipate that adequately insured consumers will experience dramatic differences in patterns of care or in the responsiveness of health services. The biggest challenges for the system will be maintaining services for the uninsured and for patients covered by public programs facing fiscal pressures and responding to the emerging needs of an increasingly elderly population.

The obvious strains are most likely to be felt in the public sector, and particularly in the financing and administration of the Medicare and Medicaid programs. Also, as more of the population enters the ages associated with disability and dependence, our failure to develop a coherent policy of long-term care that protects the elderly and their families at the period of greatest vulnerability will increase in salience and will become a more explosive social issue. We would do well to face the restructuring of Medicare and Medicaid, and the development of long term care policies now, before the demographic and financial implications push us into expedient but poorly conceived solutions.

The Demographic Scenario

The awesome consequences of the aging of the American population, and its implications for dependency and medical and social services costs, are now commonplace. The population age sixty-five years and over has increased from 8.1 percent in 1950 to approximately 12 percent now, and will continue to increase moderately until 2010, when this age group will constitute almost 14 percent of the population. In the subsequent two decades as the postwar birth cohorts reach age sixty-five, the proportion is expected to increase to approximately 21 percent. The population age seventy-five and older, now constituting two-fifths of those over sixty five, will increase to almost half in the next twenty-five years.

Age distribution is largely a product of the size of varying age cohorts and changing patterns of mortality. Trends in these demographic patterns result in dramatic increases in the numbers of elderly eighty-five years or older. Between 1960 and 1980 this subgroup increased faster than any other age group, and is expected to constitute almost 15 percent of those over sixty-five within the next fifteen years. The proportion of persons reaching age sixty-five who attain age eighty-five increased from 23 percent in 1950 to 38 percent in 1983.

Projections into the future, based on present patterns, are always a
hazardous endeavor. We have been less than accurate in anticipating changes in social and political values, new knowledge and technologies, trends in economic well-being, attitudes toward income redistribution, and the occurrence of new epidemics. As we project into the future, we can be confident that our extrapolations from the past will be faulty, but failure to plan seriously for the inevitable would be foolish indeed.

Barring extraordinary and unexpected events, the changing age distribution, and particularly the growing numbers at ages where chronic illness and limitation of function are common, will put significant pressures on our systems of social welfare and entitlements. It may be that changing risks throughout the lifespan will lead to some compression of morbidity—a debatable hypothesis. However, even if the period of chronic illness and incapacity is compressed, the magnitude of the overall burden of illness will be well beyond our experience. Demographic patterns, together with scientific and technological capabilities to sustain life, already strain our social welfare structures, but we still have the luxury of some time to plan intelligently for the momentous challenges as the baby boom generations move into their later years.

With an aging society, attention is focused commonly on rates of dependency in the population and ratios of those of typical employment age relative to others. Inevitably, this suggests alarm about the falling proportion of workers relative to the population. Such ratios, projected over time, are not particularly meaningful without careful consideration of the likely trends in automation in the production of goods and services, advances in computer technologies and robotics, the number of children, and possible changes in norms and values about who should work. Growth of female participation in the labor force made projections based on earlier norms meaningless, and we need not assume that either retirement age or its downward trend is immutable. While retirements prior to age sixty-five are increasing, the factors motivating such behavior could change substantially with altered views of the lifespan, economic pressures and incentives, and new conceptions of what it means to be elderly.

It is surprising, for example, that so little attention has been given to how immigration policy over the next fifty years might help insulate the society from shocks associated with a less than optimal age distribution. Immigration policy has set quotas in relation to varying nations, occupational strata, and relationships to U.S. citizens. In theory, an immigration policy planned over a couple of decades could help smooth the age distribution to moderate some of the most alarming consequences of an aging society. This would substantially deviate from current policy and trends, but the use of immigration policy as an instrument for demographic balance is one of many possible strategies for an aging society.
The Implications Of Aging For Health Care Planning

The health status of varying birth cohorts as they approach the later years reflects a broad history of personal habits and environmental influences throughout the lifespan. There is indication that successive cohorts at different ages in middle and later life are more healthy, possibly a product of improved living conditions during their development or a result of positive health behavior that reduces exposure to risk factors. Aggregate data on health status and illness by age are not particularly informative because the inclusion of persons whose mortality is reduced or delayed through sophisticated medical measures inflates aggregate overall rates of illness and disability, which may mask other improvements in health status in the population. Increased longevity of elderly populations with serious chronic illness, however, poses serious challenges for the provision of medical and other long-term care services. As individuals move into the eighth and ninth decades of life, the probability of decreased function, dependence on others, and risk of institutionalization substantially increases. Thus, the number of individuals at risk, while only a small portion of those over sixty-five, is a relatively large segment at age eighty-five.

Long-term care for the elderly is substantially rationed by the abhorrence many elderly have for residence in nursing homes. Persons who could meet any reasonable criteria for nursing home admission hang on with the assistance of family, friends, and neighbors to avoid entering institutions. The trigger for admission is often not the level of need alone, a criterion that could be met by many living outside nursing homes, but rather the loss of a spouse or other significant supportive persons or a major illness or accident that makes persons lacking supports unable to care for themselves.

There is a perversity about a system of care that depends for its equilibrium on public abhorrence. Those elderly with significant needs for care greatly outnumber those in nursing homes. For many such patients, home and community care are preferable, and in the individual instance, economical as well. But shifting services to the community removes the barrier of abhorrence, opening increased demand that promises aggregate long-term care costs in excess of current expenditures. Herein lies the dilemma and the challenge that a prudent and humane public policy must address.

Policy Issues At The Federal Level

Cost-containment pressures affect government programs acutely because the federal government pays a large proportion of total health expenditures (28.9 percent in 1983), because health care costs constitute
a significant component of the federal budget (over 12 percent in 1983), and because health expenditures make up even a larger proportion of the federal budget under administrative and legislative control. Given its magnitude and discretionary possibilities, it becomes an area of close scrutiny in times of budgetary constraint. Projections of the expected insolvency of the Medicare Trust Fund have been pushed forward as the economy has improved, but demographic realities will require us to reassess the future structure of Medicare, and to face the inadequacies of long-term care provision,

Ideally, we seek a program that eases access to high-quality care among those who most need care; distributes entitlements in an equitable way; protects vulnerable individuals and their families against catastrophic costs; and shapes incentives for professionals, patients, and caretakers to promote improved function and rehabilitation efforts. Notwithstanding the ambiguity of such terms as access, quality, need, and equity, it seems clear that in addition to Parts A and B (hospital costs and physicians’ services, respectively), as currently constituted, Medicare should include protection against catastrophic acute care costs. But this is only a small part of the problem. A strategy for long-term care is required that makes it possible for the most needy to obtain care without first impoverishing themselves or their families, a common occurrence in many jurisdictions under Medicaid regulations. Medicare costs cover only 44 percent of health care costs of the elderly, and recipients now contribute a larger proportion of income out-of-pocket than they did prior to 1966 when the program was implemented. In some subgroups, such expenditures exceed acceptable levels of total income.

The responsibility of the elderly. As we examine ways of reducing cost sharing for those with least income, there is also merit in examining carefully the capacity of some elderly to take responsibility for greater costs as a way of protecting and enhancing the benefit structure. Alternative approaches include taxing the value of the Medicare benefit among recipients whose incomes exceed a defined ceiling, eliminating other preferences to the high-income elderly such as the additional tax deduction, or taxing more Social Security income above a specified income level. Means testing is increasingly suggested but would alter the program irrevocably. The beauty of Medicare is its universality and its acceptance and support across all social groups in the population. Unlike Medicaid, it is not a welfare program and is immune to the stigma and distrust commonly associated with the Title XIX program.

The obvious needs to address catastrophic costs and to plan more appropriately for long-term care would suggest greater dependence on general revenues. In the context of a large deficit, an ideology supporting the contraction of the federal government, and resistance to increased taxes, this is no easy matter, and identifying ways to reduce program
expenditures will continue to be the main emphasis of public policy. In the absence of increased revenues, there are four general alternatives: changing eligibility criteria to reduce the pool of beneficiaries, increased cost sharing, continued tightening of reimbursement, and modifying the benefit structure. Most of these alternatives are not desirable, but we probably will see efforts in all of these areas.

The problems of Medicare and Medicaid are not isolated issues but should be seen in the context of health subsidies in general. Recently, Enthoven estimated that the tax subsidy of health insurance benefits was almost $50 billion and likely to increase as a result of a recent Internal Revenue Service (IRS) ruling permitting health insurance premium contributions to be purchased with before-tax dollars when certain conditions are met. While some subsidy encouraging health care insurance is defensible, existing subsidies have encouraged overinsurance among the affluent, which, if we take the Rand Health Insurance results seriously, contributes little to improved health status but increases utilization and cost.

There is broad recognition of the inequity of this subsidy, but those who benefit from it have been effective in resisting its modification. Revision may be more feasible, however, within a framework that reallocates the subsidy to address such issues as catastrophic costs, long term care, and the needs of the uninsured and those institutions that provide much of their care. Reducing a tax benefit to lower federal expenditures may be less compelling than devising a more equitable and acceptable framework for care overall. The latter, if well designed, could coalesce a range of influential constituencies that would potentially provide the necessary political momentum.

The role of public financing. A major challenge is to maintain the universality of Medicare, but in a context that offers broader protection against catastrophe and a mode of financing that protects low-income recipients from burdensome levels of cost sharing. The increased cost sharing in Medicare involving an inpatient deductible of $520 for each period of illness, a $75 deductible and 20 percent coinsurance for approved doctors’ charges, and heavy coinsurance for hospital stays exceeding sixty days results in devastating costs in individual instances. Approximately two-thirds of Medicare patients protect themselves by purchasing Medigap insurance that covers much of these costs, but such policies are expensive relative to the benefits provided because of marketing, administrative costs, and profits. Medicare could provide expanded benefits at no greater cost than the elderly now pay for Medigap protection. This approach was suggested by the Social Security Advisory Council, advocated by the Secretary of the Department of Health and Human Services, and is now being considered by Congress.

The 30 million Medicare recipients are a highly varied group, eco-
nomically and otherwise. Disparities in income are large and tend to be underestimated, since affluent elderly receive a larger proportion of their resources from unearned income that is not fully reported. A significant proportion of elderly have modest incomes (approximately half within 200 percent of the poverty line) but are not sufficiently destitute to be eligible for Medicaid. Thus, health expenditures may usurp an intolerable proportion of their income, preventing them from fulfilling other needs. One approach to remedying the uneven result of cost sharing is to provide a tax credit to recipients whose out-of-pocket health expenditures exceed some reasonable proportion of income. Those whose incomes, in contrast, exceed specified levels could be taxed on the average value of the Medicare benefit.

Much attention has been focused on efforts to tighten reimbursement under Medicare and the implementation and consequences of Medicare’s prospective payment system (PPS). The growth of physician payment under Medicare Part B has also stimulated a variety of measures to control physician payment, including a freeze on fee increases. (Payment to physicians increased 106 percent between 1979–83, almost three times the gross national product.) The unwillingness of many physicians to accept Medicare assignment puts the burden of payment on the elderly for charges beyond those allowable by Medicare. This can substantially inflate required out-of-pocket expenditures. Various proposals are being considered to encourage physicians to accept assignment, as well as mandatory assignment approaches. There is concern that mandatory assignment would make physicians less accessible to the elderly, but, given the important contribution Medicare makes to physician income, the growing numbers of physicians, and the increasing competition for patients, it seems unlikely that many physicians would opt out of Medicare. Measuring the quality and responsiveness of care, in contrast, is more difficult, but fears about diminished attention to patients with mandatory assignment constraints, particularly in light of the increasing competitiveness of the arena, may be exaggerated.

Medicare’s PPS constitutes a stage in the evolution of a more comprehensive prospective payment system. On the one hand, more thought is being given to extending the PPS approach to other services such as nursing home payment and inpatient physician services. On the other hand, serious efforts are being made to enroll the elderly into capitated arrangements, such as health maintenance organizations (HMOs), in which the health entity assumes the risks of unanticipated costs. PPS, as it now operates, is simply a tool to control payments. We can anticipate increased efforts to refine diagnosis-related groups (DRGs) to control for complexity of care. Also, we can expect reduced payments as economic pressures in the program increase and better hospital performance data that justify modifications become available.
Hospital and physician reimbursement policies reflect the need to control program costs and, it is hoped, to encourage efficiency, but processes of decisionmaking within the hospital remain uncertain. It is not obvious that constraints result in wise decisions or that managers in hospitals have the authority to constrain physician behavior constructively. With the increased availability of physicians, managers have more options, yet their dependence on physicians’ patients in a highly competitive situation has countervailing influences. We need a much better, more detailed understanding of how decisions are worked out in this context. Peer Review Organizations and other regulatory authorities, and the rapidity of change, add to the reasons to anticipate major gaps between theory about the internal responses of hospitals and reality.

**Strategies For Long-Term Care**

In the absence of a national strategy for long-term care, and the exclusion of long-term services from Medicare coverage, Medicaid, by default, constitutes our national long-term care program, financing approximately half of national nursing homes expenditures. The cost of long-term care taxes the resources of most families, and typically elderly entrants to nursing homes on their own resources spend down until they reach eligibility for Medicaid. In the case of a family unit, however, the patient’s elderly spouse is commonly forced into poverty before eligibility is reached, a situation that shocks the conscience of the public. The problems of building a long-term care constituency are exacerbated by the common belief among the public that Medicare provides needed protection. Four-fifths of members surveyed by the American Association of Retired Persons, who thought they might require long-term care in the future, believed that all or most of the costs were covered by Medicare or private insurance.

**Community based care.** The goal is to develop an appropriate strategy for financing long-term care within a framework that enhances continued participation and function in the community to the greatest extent possible, and reinforces the informal care and supports that currently exist. When home care is no longer feasible because of mental confusion, incontinence, and extreme disability, and when the burdens on caretakers become too large, we seek a competent and caring institutional environment.

Considerable consensus exists on goals, but the enormous potential costs of long-term care give most policymakers reason to pause. More attention is now being given to the potential of long-term care insurance and community organizational structures that can bring together and coordinate a broader range of care needed by the frail elderly. The current social health maintenance organization (SHMO) demonstrations
supported by the Health Care Financing Administration (HCFA) should provide useful information on the viability of this approach.

Intuitively, it seems plausible that if we appropriately organize home and community services for the elderly, we should be able to provide high-quality care at a cost comparable to or less than that of institutional care. But what seems intuitively plausible is not necessarily true, and we have much to learn about how better to target individuals truly at risk of institutionalization who can, with appropriate services, remain in the community. Moreover, when individuals are sufficiently debilitated and confused, and require sophisticated services and high levels of supervision, institutional care may be the less expensive alternative. Similarly, the burden on caretakers must be factored into consideration. In short, we need better concepts of triage that identify what patients and needs are most appropriately cared for in varying service contexts.

Cost per person must be differentiated from aggregate costs for populations. Most elderly hang on in the community as long as possible. But an attractive community/home care benefit brings new clients, who contribute to a higher aggregate cost. Such benefits often become complements rather than substitutes. These new clients who are attracted to community care benefits are in need but less disabled than those at high risk of institutionalization. Patients with such characteristics who enter nursing homes frequently return to their own homes after a relatively short stay. Thus, while community care may be preferable, it must be justified on the basis of community values and quality of care, and not as a cost-saving alternative.

**Eligibility screening.** If long-term care needs are to be met by a broader set of options than now exists, and at tolerable cost, then screening for eligibility for services must be an important component of any program. Sophisticated evaluation is essential, but screening costs can be expensive because those at risk are a small proportion of the frail. The preservation of informal supports is extremely important, but can be undermined if programming strategy is not mindful of the extent to which community sustenance depends on this hidden system of care. Incentives can reinforce and strengthen these informal networks by helping reduce burdens on caretakers and providing respite opportunities.

**Sources of funding.** If long-term care financing is to be responsive to the evolving need, then various sources of funding will be necessary. Future cohorts of elderly will have more resources in the form of pensions and other assets, and there is growing interest in such mechanisms as long-term care insurance, long-term care individual retirement accounts (IRAs), and reverse mortgages. Structuring a combination of these mechanisms, along with direct governmental support, is a complex endeavor involving a variety of questions for which good data are not easily available. Despite strong constraints on the long-term care sector, it
has grown rapidly. Nursing home care increased from less than 2 percent to 9 percent of personal health care costs, between 1950 and 1983, with estimated expenditures of $35 billion in 1985. Approximately 46 percent of expenditures come from public sources, with more than two-thirds from federal programs, primarily Medicaid. Long-term care services provided in the community and home are difficult to disaggregate from other health and social services in the community, but still constitute a small fraction of long-term care expenditures.

The dilemma faced by both public and private programs is how to expand long-term care services and better respond to community needs within acceptable economic limits without unleashing a high level of demand that exceeds the capacity or willingness of the community to pay. The problem is somewhat different for the affluent with assets, who might buy long-term care protection through private insurance, life care community residence, or other means, and the majority of elderly with limited assets who inevitably must depend on public programs. But, in either case, mechanisms must be in place to assure the viability of economic arrangements.

**Rationing services.** The strategies for rationing long-term care services are comparable to those used in the health sector generally. But because they involve skills and services that can be more easily met by informal sources such as homemaker assistance, chore services, meal preparation, transportation, and some home nursing services, the potential for shifting informal costs to programs is large. This presents difficult actuarial problems and encourages restrictive insurance options. Any adequate long-term care provision probably would require considerable cost sharing not only to reduce the obligation of third-party payers but also to establish a threshold beyond which persons who have alternative informal sources are less likely to seek benefits. Deductibles and coinsurance must not be so large as to inhibit the provision of essential services, but must be large enough so that there is no obvious incentive for family and friends to shift responsibility. This is an exceedingly difficult issue because objectives are in conflict and defining the proper balance of incentives is fraught with uncertainty.

An alternative or complement is to have case managers make decisions about benefits through the application of screening criteria. Such judgments about community and home services are far more uncertain than are decisions about nursing home admission, and much effort is needed in perfecting such criteria. The task is more difficult than decisions about necessary medical services, and requires judgments not only about what persons can do on their own, but also about the strengths and capabilities of their families and extended informal networks. This task, thus, is inextricably associated with complex personal and social values, norms about the obligations of the family, notions about what friends owe to
one another, and the like. The area thus involves difficult ethical issues and assessments and is highly vulnerable to the excesses of discretion and inequitable outcomes. We should learn something about this process from the ongoing SHMO demonstrations, but the inherent problems are not easily solved. Discretion can be contained to some degree by specifying in detail the conditions under which varying types of services would be available. The exercise might be informative for those managing such a program, but it is difficult to visualize how the complex judgments involved can be prescribed sensibly.

Long-Term Care And Society

Long-term care is a social process, more so than is the provision of traditional health care as we usually view it. It depends to a larger degree on notions of community, networks of reciprocal obligation, and competing and changing values among the generations. In a narrow sense, the challenge of long-term care is in developing a financial structure that assures that the pressing needs of the sick and disabled elderly will be met. But any viable financing structure must be developed within a meaningful community context and consistent with efforts to sustain voluntary efforts.

For those elderly who lose their capacity for social relations as a consequence of Alzheimer’s disease, stroke, or other devastating infirmities, the major challenge is financing the care that informal sources are unable to give without insufferable burden. But for many disabled elderly, the challenge is to sustain their function and participation and to maintain their sense of self and personal dignity. Thus, the source of care, and how it is provided, is no small issue. If the elderly view the substitute of formal care for informal services, whatever the quality, as a betrayal by loved ones and the community, the results will be deficient.

While most elderly prefer community to institutional care, their desire to avoid financial dependence on their children is highly prevalent and has increased over time. Thus, it seems plausible that as the population contemplates increased longevity and the prospects of aging, and becomes better educated about the inadequacy of long-term care protections, it will be more prepared to invest in protecting against the risks of incapacity and dependence. Approximately one in five of those over sixty-five now require nursing home care, but as the demographic composition of the elderly group changes, needs for care will increase. If the risk is sufficiently spread over the population, the burden on any individual need not be excessive.

Possibilities for long-term care coverage range from mandatory program participation through an extension of the social security system to private long-term insurance embodied in employee benefit plans or
purchased on the open market. To the extent that such coverage is not mandatory, the usual problems of marketing, risk selection, and public education are major concerns, and leave open the question of how we care for those who lack the necessary prudence or who play the odds in addition to those who lack the economic resources to protect themselves.

Ironically, our society has the facilities, the capacity, and the human resources necessary to ensure our population decent care. With our abundant institutional capacity, our growing corps of physicians, nurses, social workers, and other health professionals, and our strong tradition of volunteerism, we have the necessary components for a comprehensive and vital response to the challenges. The growing elderly population itself is a major resource that can contribute immensely with creative organization. Many retired persons seek fruitful opportunities to serve others and to maintain their sense of meaningful participation. We have yet to develop appropriate organizational contexts on a wide scale that can utilize this rich reservoir of productive activity.

Long-term care must be seen not simply as a medical or custodial problem, or solely within the larger context of providing social services. Effective long-term care requires major initiatives in social organization and the modification of community culture along with the health and social services that those with impaired function require. It is through a balance of increased public entitlements, nongovernmental initiatives, enhanced voluntary efforts, and individual responsibility of the elderly and their families that we have an opportunity to provide not only the critical services that a decent society demands, but also a framework that gives the later years meaning and dignity.
NOTES

17. Ibid.