Prologue: In an era when the long-term care needs of the elderly are growing, the federal government has been reluctant to embrace new policies that would expand the availability of such services. The concern of government has revolved around the potential high cost of long-term care. In the absence of major new policies, Congress has authorized a number of demonstrations, seeking to identify what may work and what should be discarded as possible future program directions. One of these demonstrations authorized small rural hospitals to use their beds interchangeably to provide either acute, skilled, or intermediate care for their Medicare patients. In this article, authors Hila Richardson and Anthony Kovner discuss the evolution of the so-called swing-bed concept since Congress enacted this provision seven years ago. One of the interesting details they discuss is the degree to which this provision, a seemingly practical solution to the twin problems of a shortage of nursing home beds and a decline in rural hospital occupancy, became a subject of controversy. Some of the controversy was provoked by the competing economic interests of hospitals and nursing homes. This conflict is not limited to the swing-bed provision. At the state level, the hospital and nursing home lobbies are constantly engaged in economically based struggles serving the elderly patient. Richardson, who holds a doctorate in public health from Columbia University, is senior director of the Office of Long-Term Care, New York Health and Hospitals Corporation. Kovner is a professor of public administration at New York University and director of its graduate program in Health Policy and Management. Richardson and Kovner were, respectively, associate director and director of The Robert Wood Johnson Foundation’s Rural Health Care Program. The program will award $9 million in grants and $7.5 million in loans to some fifteen groups of hospitals that plan to reconfigure their health services and, in the process, improve their financial viability.
Swing-bed legislation, enacted in 1980, allows small rural hospitals to use their beds interchangeably to provide either acute, skilled, or intermediate care for their Medicare patients. Hospital reimbursement depends on the level of care provided. As of 1986, close to 800 hospitals were certified by Medicare to provide swing-bed services. This represents approximately one-half of the eligible hospitals in the nation.

Swing-beds are one approach to addressing two problems in rural communities: the shortage of nursing home beds and the decline in rural hospital occupancy. Historically, rural hospitals provided both acute and long-term care. Medicare and Medicaid, however, required that skilled-nursing and intermediate-level care be provided in a physically distinct part of the hospital used exclusively for these purposes and with different health, safety, and staffing requirements and reimbursement. Many small rural hospitals had trouble meeting the requirements because of physical plant limitations, limited accounting abilities, and lack of specialized clinical personnel. Often, a rural community did not have enough patients to make a distinct unit financially viable. Consequently, most rural hospitals were not able to implement the distinct-part option.

State payment policies, certificate-of-need regulations, and moratoria have restricted long-term care bed supply for Medicaid patients and made it difficult for the nursing home industry to meet the demand for long-term care in rural areas. In addition, there is a shortage of beds in Medicare-certified skilled-nursing facilities (SNFs) because of the nursing home industry’s unwillingness or inability to meet the Medicare certification standards or to provide the intensity of care required by skilled-level patients. Also, there often are not sufficient private-pay patients to support skilled nursing facilities in rural areas.

The second problem is the decline in rural hospital occupancy. Although part of a national trend, the decline stems from several factors specific to rural areas. These include the shrinking of the rural population base, particularly those under sixty-five, and the loss of patients to larger hospitals and referral centers. The resulting excess in acute care bed capacity, combined with the shortage of extended-care beds in rural areas, led the federal government to sponsor an experimental program in hospital swing-beds. From 1973 to 1981, 108 rural hospitals in Iowa, South Dakota, Texas, and Utah participated in this federal demonstration, which was evaluated by the University of Colorado Health Sciences Center. Largely based on this experimental effort, the Omnibus Budget Reconciliation Act of 1980 authorized Medicare and Medicaid payment for swing-bed services in rural hospitals with fewer than fifty beds.

Twenty-six of the nearly 800 hospitals certified by Medicare to provide swing-bed services are part of a national demonstration project funded by The Robert Wood Johnson Foundation and administered through the Program in Health Policy and Management at New York
University. The project, known as the Rural Hospital Program of Extended-Care Services, began in April 1981 as an effort to promote the swing-bed concept by setting up "models" of how small rural hospitals can provide high-quality long-term care services. As part of the demonstration, the hospitals have received educational and technical assistance from the hospital associations in the five states in which they are located. The hospital associations also have received Johnson Foundation grants. In February 1986, the foundation sponsored a conference at the Brookings Institution to assess the policy implications of swing-beds.

This article summarizes hospitals’ experiences in the demonstration project and information presented at the conference. It reviews swing-bed legislation, presents demonstration project data, and discusses positive and negative aspects of the impact of swing-beds on the rural elderly, rural hospitals, and payers who cover swing-bed services. The article’s scope is limited to discussing swing-beds as one approach to addressing the problem of excess hospital capacity and the need for long-term care in rural communities. Other options, such as closing or converting excess beds and developing noninstitutional sources of long-term care, are not mutually exclusive with swing-beds and should be explored.

### Conditions Of Participation

In July 1982, the Health Care Financing Administration (HCFA) implemented legislation authorizing swing-beds. HCFA outlined the following conditions of participation.

**Size and location.** Participation in the Medicaid and Medicare swing-bed program is limited to rural hospitals with fewer than fifty inpatient beds. The regulations allow hospitals to count all inpatient beds maintained by the hospital, exclusive of beds for newborns, in intensive care units, and in nursing home distinct parts. HCFA has interpreted this provision to include hospitals licensed for more than fifty beds if the hospital has staff for or is operating fewer than fifty beds. In addition to bed size and location requirements, the hospital must obtain a certificate of need for provision of skilled nursing or intermediate care services, if required by the state planning agency.

**Quality standards.** Implementing regulations require that, in addition to accreditation by the Joint Commission on Accreditation of Hospitals (JCAH) or HCFA’s hospital conditions of participation, swing-bed hospitals must comply with SNF conditions of participation for patients’ rights; specialized rehabilitative, dental, and social services; patient activities; and discharge planning. However, not all SNF standards are applied to swing-bed hospitals. For example, the hospitals do not have to provide a separate dining area for SNF patients.

**Reimbursement.** Medicare reimburses separately for routine care-
room, board, and nursing—and for ancillary services for swing-bed patients. Routine services are reimbursed based on the average Medicaid SNF routine rate per day during the previous calendar year in the given state. Ancillary services are reimbursed based on costs, that is, total costs of the services accounted for by Medicare charges as a proportion of total charges. Medicaid reimbursement was virtually identical to Medicare’s until the Deficit Reduction Act of 1984 modified the Medicaid provision to allow states more flexibility in setting rates. As a practical matter, however, most states follow the Medicare reimbursement principles.

**Review Of The Data On Swing-Bed Services**

The number of hospitals participating in the swing-bed program has grown rapidly, from 149 in December 1983 to 771 in December 1985, an increase of more than 400 percent. This means that approximately one-half of the 1,370 to 1,649 eligible (depending on the definition of eligible) hospitals are certified by Medicare.’ As of December 1985, there were swing-bed hospitals in thirty-nine states; seventeen states had more than 50 percent of the eligible hospitals. The twenty-six hospital grantees in the Johnson Foundation’s project are included with these hospitals.

These data on swing-beds are from the three-year experience (1983-1985) of the twenty-six hospitals in the Johnson Foundation’s project. Although these hospitals are representative of small rural hospitals in general, their experience with swing-beds has differed because of grant support. For example, preliminary results from the swing-bed evaluation indicate that, among other differences, other swing-bed hospitals have higher utilization, more intense medical case-mix, and shorter lengths-of-stay than the demonstration hospitals have.

**Utilization.** For the first three years of the demonstration, the grantee hospitals had an annual average of sixty swing-bed admissions and 1,225 swing-bed patient days (Exhibit 1). During 1985, the hospitals attained

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<tbody>
<tr>
<td>Swing-bed admissions</td>
<td>847</td>
<td>1,770</td>
<td>2,041</td>
<td>1,553</td>
</tr>
<tr>
<td>Swing-bed patient days</td>
<td>17,920</td>
<td>36,860</td>
<td>40,804</td>
<td>31,861</td>
</tr>
<tr>
<td>Average length-of-stay (in days)</td>
<td>21.2</td>
<td>20.8</td>
<td>20.1</td>
<td>20.6</td>
</tr>
<tr>
<td>Acute care days</td>
<td>162,067</td>
<td>116,740</td>
<td>94,606</td>
<td>124,471</td>
</tr>
<tr>
<td>Swing-bed days as percent of total</td>
<td>10.1</td>
<td>24.4</td>
<td>30.2</td>
<td>26.0</td>
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<tr>
<td>hospital days</td>
<td></td>
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*Source: Summary of quarterly data reported by the twenty-six grantee hospitals in the Rural Hospital Program of Extended-Care Services, a national demonstration project of The Robert Wood Johnson Foundation.

*Numbers represent totals for the twenty-six grantee hospitals.*
their highest average number of swing-bed patient days at 1,569 per hospital. The average length-of-stay over the three years was 20.6 days and has remained relatively constant throughout the program. Of the swing-bed patients, 42 percent have stayed in swing-beds less than ten days, and 84 percent have stayed less than thirty days during the three years. In 1985, swing-bed patient days represented 30 percent of total patient days in the grantee hospitals, compared to 10 percent in 1983.

**Characteristics of swing-bed patients.** The characteristics of the typical patient using swing-bed services over the duration of the program have remained relatively unchanged. As shown in Exhibit 2, the typical patient is a white, female widow who is age seventy-five or older and who requires a level of skilled-nursing care that is covered by Medicare. The

<table>
<thead>
<tr>
<th>Exhibit 2</th>
<th>Characteristics Of Swing-bed Patients In Grantee Hospitals, 1985</th>
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<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Less than 65 years</td>
</tr>
<tr>
<td></td>
<td>6.4%</td>
</tr>
<tr>
<td><strong>Race/ethnicity</strong></td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>91.0%</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>40.0%</td>
</tr>
<tr>
<td><strong>Level of care</strong></td>
<td>Skilled</td>
</tr>
<tr>
<td></td>
<td>74.2%</td>
</tr>
<tr>
<td><strong>Source of payment</strong></td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>61.1%</td>
</tr>
<tr>
<td><strong>Residence before admission</strong></td>
<td>Alone (private)</td>
</tr>
<tr>
<td></td>
<td>31.0%</td>
</tr>
<tr>
<td><strong>Primary reason for admission</strong></td>
<td>Fracture</td>
</tr>
<tr>
<td></td>
<td>17.7%</td>
</tr>
<tr>
<td><strong>Residence after discharge</strong></td>
<td>Alone (private)</td>
</tr>
<tr>
<td></td>
<td>12.3%</td>
</tr>
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</table>

*Source: Annual summary of quarterly data reported by the twenty-six grantee hospitals in the Rural Hospital Program of Extended-Care Services, a national demonstration project of The Robert Wood Johnson Foundation.*

*Skilled nursing facility.
patient is admitted initially to the hospital from a private residence where she is living alone or with family members. The most common reason for admission to acute care is a fracture or stroke. During a swing-bed stay, about half of the patients receive physical therapy. Upon discharge, there is slightly more than a 50 percent chance that the swing-bed patient will return to live alone or with family members; a 24 percent chance that the patient will be discharged to a nursing home; and a 4 percent chance that the patient will have other living arrangements, such as in residential facilities, after leaving the hospital. Readmission to an acute level of care occurs 11 percent of the time. Between 9 and 10 percent of the patients die while at a swing-bed level of care.

**Reimbursement.** The average skilled and intermediate reimbursement rates for swing-bed care in 1985 for the demonstration states have ranged from $35.87 to $69.71 per day for skilled care and $28.62 to $43.03 per day for intermediate-level care. Grantee hospitals report that ancillary charges average between $30 and $50 per swing-bed day.

At the end of 1985, 61 percent of swing-bed patients were covered under Medicare, 18 percent were self-pay, 11 percent were covered by Medicare and Medicaid, 6 percent were covered under the state’s Medicaid plan, and the remaining 4 percent were covered under other insurance or pension plans. Most of the patients in the self-pay category are patients who no longer require Medicare skilled-nursing care and who do not meet the state’s criteria for Medicaid eligibility to cover their stay at an intermediate level of care.

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**Impact On The Rural Elderly**

**Improved access.** Shaughnessy’s ongoing evaluation of the national swing-bed program concludes that access to institutional long-term care for residents of rural communities has been improved by the availability of swing-beds. More specifically, he has found that long-term care patients with more intense medical need have greater access to needed services where there are swing-bed hospitals. Such hospitals were more likely to serve a higher portion of these “heavy-care” patients than nursing homes were. He also found that a higher proportion of rural residents remain in their communities with swing-bed services than in communities where swing-beds are not available. Finally, he concluded that there is a significantly greater proportion of Medicare long-term care days and a slightly higher proportion of private-pay patients in swing-bed hospitals than in community nursing homes.

Shaughnessy’s findings are limited to the impact of swing-beds on access to institutional long-term care, and he does not address the community-based services such as home health care. What impact the
availability of swing-bed services has on meeting the need for all long term care services in a community would require further study using population-based data on total need.9

Quality of services. The goal of swing-bed hospitals to provide high-quality long-term care in an acute care setting requires changing the hospital staffs focus from the acute model of diagnosis-centered, largely physician-dominated care to a focus on multidimensional needs and nursing-centered care. According to Smits, it is easier for hospitals to do well in those aspects of swing-bed care more closely related to acute care, that is, meeting the basic medical and nursing needs of a medically intensive patient and providing services such as laboratory and diagnostic tests.10 However, Smits believes that hospital staffs have more problems than nursing home staffs in areas outside their traditional acute care roles such as patient activities and functional assessment.

The grantee hospitals report that most of their difficulty stems from the few swing-bed patients, usually three to five, in the hospital at any one time. Working with a few swing-bed patients along with acute patients requires staff to change gears in their attitude toward and expectations of the patient. As the role of the staff remains primarily acute care, it is difficult for them to gain expertise in functional assessment skills and long-term care-planning and documentation. Further, as 40 percent of the patients stay fewer than ten days in a swing-bed, this leaves less time for observing and documenting change in physical and mental function. Completing one assessment per patient may be all that is feasible, leaving staff with a sense of incompleteness and frustration. Finally, with the small number of swing-bed patients, the patient activities program—an important aspect of meeting the psychosocial needs of the long-term patient—often must be organized for each patient rather than for a group of patients, as is done in nursing homes, thus requiring more staff time per patient.

Swing-bed demonstration hospitals have shown the greatest potential for quality improvement compared to nursing homes in providing a continuum of care from hospital admission through the transition to home or nursing home placement; improving the quality of life of long-term care patients by providing access to care near family and friends and avoiding the trauma of transfer out of the community when unnecessary; and providing better access to medical care and support services such as respiratory therapy and lab services.

Other benefits to patients. The Johnson Foundation demonstration hospitals have reported unanticipated benefits to all patients from implementing a swing-bed program. The increased availability of specialized personnel, the inservice education on the special needs of the elderly, and the multidisciplinary care planning and documentation required for
swing-bed patients have made hospital staff more aware of the rehabilitative and psychosocial needs of all patients, particularly elderly acute patients. Many hospitals have integrated acute and swing-bed care planning and now review all patient care using a multidisciplinary approach. Also, the emphasis on development of quality-assurance programs for swing-bed patients has encouraged hospitals to begin or improve these programs for acute patients as well.

Introducing special services required by the conditions of participation—physical, occupational, and speech therapies; social services; and discharge planning—has made these services available to acute patients for the first time in most hospitals. Acute patients also use patient activities, another required service, as hospital staff have come to appreciate the benefits to patients needing socialization or sensory stimulation. Finally, swing-bed programs have allowed hospital staff, especially nurses and other specialized staff, to take more responsibility for the care and daily monitoring of patients previously provided by physicians. Sharing of information through documentation on the patient’s chart and informal discussion have increased communication and engendered mutual respect among physicians and other staff, which benefits all patients.

Impact On Rural Hospitals

Financial benefits. Preliminary estimates indicate that current levels of utilization can generate new revenue for rural swing-bed hospitals. The evidence to date suggests that swing-bed revenue averaging approximately 8 percent of total inpatient revenue is sufficient to cover the costs of the program and, in most cases, benefits hospital operations by reducing deficits or increasing surplus.11

Swing-beds also can provide indirect financial benefits to hospitals. One example is providing swing-bed services under the prospective payment system (PPS). With swing-beds, the patient requiring long-term care can be transferred immediately to the appropriate level of care, thus avoiding lengthy acute-care stays while awaiting placement in a nursing home. Each swing-bed admission is reviewed for appropriateness by the state’s professional review organization (PRO) before the hospital is reimbursed for services it has already provided. The hospital risks Medicare payment being denied for swing-bed care if an inappropriate or premature transfer to swing-beds has occurred.

A second indirect financial benefit is the availability of a core of specialized personnel, such as a physical therapist and social worker. This increases the feasibility for the hospital to expand the range of services offered to all patients and helps compensate for any decreases in acute care revenue. Swing-beds also have benefited hospitals by acting as a springboard for diversification, particularly into other services for the
elderly. The swing-bed program is often the first experience with non-traditional hospital acute care roles that hospital staff and boards of trustees have; they may become more receptive to trying new services after a successful experience with swing-beds. Hospitals have used Johnson Foundation grants to diversify into services for the elderly once it became apparent that such diversification was a logical next step.

Other indirect benefits that relate to the swing-bed program include using nursing staff more efficiently during periods of low acute census, increased referrals back to the hospital from large and urban hospitals, and improving the hospital’s image and visibility, which makes it easier to recruit physicians and encourages use of all the hospital’s services.

Common problems encountered. While grantee hospitals have benefited from their swing-bed programs, all of them have faced problems. Two of the most common are staff resistance to the program and recruiting specialized personnel required by the conditions of participation. Other problems are usually related to the special characteristics of a particular hospital, such as geographic isolation, poor management, and staff conflict or turnover.

Staff resistance, particularly among the nursing staff, stems primarily from the additional responsibilities required for long-term care patients. Support from the director of nursing is critical to address this problem. Often these problems can be ameliorated through frequent education and more experience with the program. In some cases, staff resistance has turned to support as they realize the importance of the swing-bed program in keeping them employed.

The nature and location of small rural hospitals make the problem of recruiting and keeping specialized personnel more difficult to solve, particularly if their services, such as social work and patient activities, do not generate revenue. Also, it is difficult to attract specialized personnel to remote rural areas. The hospitals have had some success with part-time contracts whereby the specialized staff visit the hospital and supervise others. In some cases, sharing staff with a nursing home or home health agency has worked. Hospitals with distinct parts or those near nursing homes or larger hospitals have had an advantage in recruiting specialized personnel because there are larger numbers of patients to support sufficient employment.

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<tr>
<td>The swing-bed program was not intended to be a direct cost-containment initiative. However, the increasing emphasis on controlling the costs of the Medicare and Medicaid programs has given greater importance to the cost-effectiveness of swing-beds.</td>
</tr>
<tr>
<td>Comparing swing-bed costs. In comparing the costs of providing long</td>
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term care in swing-beds versus nursing homes, Finkler assumed that there are no available nursing home beds in communities with swing-bed hospitals. Therefore, the cost of providing long-term care in the hospital was compared to providing such care in a newly built nursing home. Finkler emphasized that excess capacity in existing nursing homes would be the least expensive alternative for a longterm care patient day.

Using new nursing homes owned by Beverly Enterprises as a basis of capital and operating costs, Finkler estimated $10.90 as the capital cost and $38.15 as operating cost per nursing home day. The calculation of incremental swing-bed costs was based on an analysis of a swing-bed hospital in North Dakota. Ranges of incremental costs were calculated for raw food, laundry, housekeeping operations, maintenance, and routine supplies and drugs. Additional labor costs were limited to individuals hired as needed for patient activities and social services. Finkler used the common assumption, based on the empirical data available, that additional hospital labor (nurses, technicians, and laundry workers) is not required because of the usually small number of swing-bed patients (three to five) on any one day. Using this case, an average per diem incremental cost of a swing-bed patient was calculated to be $26.73, compared to the cost of a patient day in a new nursing home of $49.05, making new nursing home beds 83.5 percent more expensive.

This estimated average cost of a swing-bed day at $26.73 falls below the average Medicare payment for a skilled day in many states. Reimbursement in rural states ranges from $28 to $85. The average Medicare payment for swing-beds, therefore, is likely to cover the incremental costs in most hospitals and to allow sufficient net revenue to encourage hospitals with very low acute occupancy to provide this additional service to local residents at a lower rate than if local nursing homes had to be constructed.

Other issues related to swing-bed costs are: (1) whether the costs of patients in swing-beds and nursing homes are comparable because they are getting the same services and quality of care; (2) whether the costs of short-stay, swing-bed patients and long-stay, nursing home patients are comparable; (3) if swing-bed patients are keeping open the hospitals that provide swing-bed services but that would otherwise close without unduly affecting access to acute or long-term care; and (4) how swing-bed costs compare to the cost of converting acute care beds to distinct part long-term care beds or of adding more beds to existing nursing homes when those alternatives are available.

Payment to hospitals. Holahan identified payment sufficient to encourage the use of hospital beds as one of the basic goals of a swing-bed reimbursement system. Other objectives of swing-bed reimbursement policy include: access to care for heavy-care patients; efficient facilities; high-quality care; decreasing administrative costs and complexity; equal
payment for treating similar patients regardless of setting; and eliminating differences in access to institutional long-term care across states.

In reviewing the current swing-bed reimbursement approach and applying these objectives, Holahan concluded that the current reimbursement system meets few of these objectives other than administrative simplicity. The system is unlikely to encourage participation in the swing-bed program over the longer term because it covers only variable and not fixed costs, does not encourage access for patients requiring heavier care, provides no incentives for quality, and pays different rates for patients with similar characteristics. Holahan also advised that the system for swing-bed reimbursement be integrated with Medicare payment for skilled nursing facilities to avoid inequities in payment for similar patients in swing-beds and nursing homes. An alternative objective should be to pay the full, not variable, costs of caring for patients in an economically efficient manner.

Options for changing swing-bed reimbursement would require tradeoffs among access, cost, and hospital participation. Although the current policy does not meet all of Holahan’s specifications, it has provided access to institutional long-term care to a number of elderly at less than the cost of care in new nursing home beds and has paid hospitals at a rate sufficient to get more than half of the eligible hospitals to provide such care within the first three years. The reimbursement rate also has made some contribution to easing their financial deterioration.

**Implications For The Future**

Since its enactment by Congress in 1980, the swing-bed program has generated controversy far beyond its proportionately small expenditures because the program raises fundamental questions about how the acute and long-term care systems should be organized and financed. More narrowly, some of the controversy has been expressed in terms that cut across the goals of improving access, achieving high-quality care, aiding rural hospitals, and achieving cost-effectiveness or cost containment. These themes are generated by the different interests and perspectives of the nursing home industry, the hospital industry, government, and patients. Wiener has identified the following crosscutting questions or themes: (1) To what extent should there be a “level playing field?” Should swing-bed hospitals be exempt from certain requirements that nursing homes and distinct-part units of hospitals must meet? (2) Should there be equal payment for equal services or should emphasis be put in maximizing hospital participation? (3) Should hospitals or freestanding nursing homes provide long-term care? Are there real issues related to quality of medical and nursing care that makes one setting preferable for certain types of patients? As it has been debated, especially at state levels,
the issue often is reduced to a fairly crude battle over market share. (4) To what extent does the swing-bed program result in double payment to hospitals for services already included in the Medicare diagnosis-related group (DRG) payments and, if so, should this be discontinued and how? (5) To what extent does the federal government wish to incur the cost of improved access to long-term institutional care?\(^1^8\)

Despite controversies, the swing-bed program has grown. As Vladeck has suggested, swing-beds have shown that small and resource-poor hospitals can learn to provide services they have not previously provided; that services added at the margin incur mostly variable and not fixed costs; and that it is important to try to provide services relatively close to patients’ family and friends.\(^1^9\) Building on these lessons, Vladeck argues that health care facilities should seek to provide a continuum of care rather than forcing patients into a series of rigid, bureaucratically defined institutions. He concludes that swing-beds hold promise for extension to larger and urban hospitals and as a paradigm for using acute care facilities to provide services for the mentally ill, the younger disabled, substance abusers, and the socially displaced.

Not all observers, of course, evaluate swing-beds as positively. Representing the view of the nursing home industry, Press asserts that the essence of swing-beds “is helping hospitals by sticking long-term care patients into their vacant beds.”\(^2^0\) Moreover, he suggests, the cost arguments in favor of swing-beds are faulty because hospitals fail to offer the social and recreational services that long-term care patients need. Services added at the margin may be insufficient to meet patient needs. Even worse, they may damage a community’s interest by interfering with the development of a dependable local capacity to meet those needs. Swing beds, he argues, are a makeshift approach to long-term care.

Reflecting this debate, Congress has been considering whether to expand the program to large and more urban hospitals, especially those with low occupancy or problems placing nursing home patients, or to further restrict program participation. In 1986, a bill introduced by Rep. Byron Dorgan (D-ND) recommended expansion of the swing-bed program to rural hospitals with fewer than 150 beds. At the same time, a bill introduced by Rep. Gerry Sikorski (D-MN) would have imposed significant new restrictions on the use of swing-beds, such as requiring hospital administrators to become licensed nursing home administrators.

The issue of expanding swing-beds to other settings raises questions to be addressed through experimental or demonstration programs: (1) Will current reimbursement be sufficient to cover incremental costs of swing bed services in larger hospitals? (2) Can the estimated savings for a long term care day in a rural hospital bed versus a new nursing home bed be attained in urban settings? (3) Should new swing-beds be planned for in hospital replacement and under what circumstances?
In summary, swing-beds have provided needed services not previously available to the rural elderly in their own communities and have benefited many small rural hospitals. Swing-beds are limited, however, in their potential to solve the need for long-term care in rural areas or the problems of rural hospitals with excess capacity. Other alternatives, both institutional and noninstitutional, also should be used when possible.

The swing-bed program seems to work best for patients who require short-stay, medically intensive services in small rural hospitals that can recruit the necessary specialized staff. It is not a program for all postacute patients, particularly long-stay patients, or for all small rural hospitals with excess capacity. In addition, swing-beds raise other issues, not discussed here, that must be explored. Among these are the hospital’s role in long-term care, swing-beds as a nursing home substitute, swing beds in nursing homes, and swing-beds as a deterrent to developing community-based services. Nevertheless, by encouraging hospitals to use their excess capacity to meet community needs at a moderate cost, swing beds do represent a useful approach to rural health policy.

NOTES

3. Proceedings of the conference, Swing-Beds: Experience and Future Directions,” have been published by the Brookings Institution, Fall 1986.
5. Because hospitals with fifty staffed beds can be certified for swing-bed services, the evaluators at the University of Colorado have used two definitions in counting hospitals eligible to provide swing-bed services. The first definition, hospitals with fifty beds or fewer in nonurbanized areas, yields 1,370 hospitals. The second definition uses fifty staffed beds not in small metropolitan statistical areas (SMSAs) and yields 1,649 hospitals.
7. Peter W. Shaughnessy, telephone communication.
11. Assuming total hospital inpatient revenue is $1.83 million in a typical small rural hospital,
at $350 per day for 5,220 patient days, swing-bed revenue is about 8 percent of total patient revenue. The $350 total inpatient revenue per day is based on 1984 data from hospitals in Kansas with fewer than fifty beds. The amount includes roughly $175 for routine acute services, $85 for acute ancillary services, and $90 for swing-bed routine and ancillary services.


14. Incremental costs are used in determining swing-bed costs because it is assumed that an underused hospital will incur depreciation, utilities, and other expenses at the same rate, with or without swing-bed hospitals. The incremental costs will vary among hospitals because of their existing staffing and operations. For example, one hospital may add laundry personnel to handle the increased load from swing-bed patients, while other hospitals will be able to process laundry with existing staff. In the demonstration hospitals, the salary costs are most commonly limited to part-time personnel hired as needed to provide special services (for example, patient activities, social work, and physical therapy). Additional nursing time usually is not required, since the minimum staffing levels during periods of low acute census are often sufficient to cover additional swing-bed patients.


17. Holahan, “Reimbursement for Nursing Care in Swing-Beds.”

