Long-Term Care: Sharing of the Burden

Caring for the Disabled Elderly. Who Will Pay? ALICE M. RIVLIN and JOSHUA M. WIENER, with Raymond J. Hanley and Denise A. Spence. Brookings Institution, Washington, DC, 1988. xviii, 318 pp. $29.95; paper, $11.95.

For us as individuals, as families, and as a society, the blessing of increasing longevity carries a challenge: to plan for and share equitably the growing burden of supplying long-term care to the disabled elderly. Currently, individuals are primarily responsible for their own care, and the burden is shared only for those who have no financial ability to pay for long-term care: Medicaid, a means-tested public program, pays for nursing home services and some home care for the poor and for others who have exhausted their income and assets by paying for care. With growth in the amount of resources needed for long-term care, we have an opportunity and perhaps an imperative to change the distribution of these burdens. In a carefully structured and illuminating policy analysis, Rivlin, Wiener, and colleagues use simulation to portray a stark picture of the future if no change in financing takes place, project a set of alternative futures to explore the effects of a variety of policy options, and clearly state their choice among these options. They provide an excellent framework for thinking analytically about society's choices.

A cursory look at long-term care and our society's system of providing it highlights the problems this valuable study addresses. Long-term care differs from acute health care in the needs it meets as well as in the way we pay for it. It encompasses services that compensate for physical disabilities and functional impairments resulting from disease, accidents, and aging. Although long-term care needs become more prevalent with age, they are by no means a certain accompaniment of aging: a majority of elderly people are not disabled, and only a small proportion will experience disability so severe as to require a nursing home stay of a year or more. Most long-term care is provided outside the market system, by families and friends of disabled elders. (It is important to remember that these resources, not measured in dollars or included in the present analysis, are real and not without cost.) Paid services, particularly nursing home care, can be very costly when the need for service is long-lasting. Medicare, which provides acute health care coverage to elderly Americans, does pay for some nursing home and home health care for people recovering from acute illness episodes but was never intended to cover custodial nursing home and home care. Although expenses can be catastrophic for individuals, it is difficult to buy insurance that provides adequate protection for long-term care: such insurance is not widely available and appears beyond the reach of many retirement budgets. Medicaid programs in every state step in to pay for care only when an individual has virtually no income or assets left. Medicaid now pays for care for many institutionalized people who were originally middle-income, with the long-term care budget in many state dwarfing expenditures for poor children and others that the program was initially intended to serve. In part because of state cost-containment efforts, Medicaid nursing home care suffers from poor quality and restricted availability. Although our "system" meets needs for care in some fashion for those willing to enter a nursing home and risk impoverishment, America's elderly must live with great uncertainty about whether, if they become disabled, they will be able to choose the type of setting and care to best compensate for disabilities, so that the life-tasks of their last years can be accomplished with dignity.

Rivlin, Wiener, and their colleagues at the Brookings Institution employ a simulation model (developed by ICF Inc.) to play out long-term care use and expenditure for the next three to six decades if the current system continues. The results should make Americans sit up and take notice: by the year 2020, we will spend an estimated $120 billion (measured in 1987 dollars) on long-term care, with 40%, $48 billion, coming from overstressed state budgets. The simulation is then used to explore the financial implications of a number of policy alternatives. Current trends, like the increasing numbers of women in the work force, divorce rates, and declining mortality rates, will affect the income and health of the elderly population in the future and thus its use of long-term care. Using personal characteristics and earnings histories for a sample of Americans, the model simulates future income, marital status, disability, long-term care use, and death by applying parameters gathered from many sources. Simulation thus allows a sophisticated prediction of future long-term care expenditures and more realistic consideration of alternative policies.

Of course such a simulation is only as strong as its structure and parameters, and the reader should be aware that the authors' choices have a profound effect on some projected outcomes. For example, the model assumes that an individual's probability of becoming disabled in any year of life is identical to current incidence rates, even though his or her probability of dying in any year is assumed to decline in the future. The authors present a balanced discussion of this controversial assumption, involving whether we are adding disabled or healthy years to our lifespan, and present some sensitivity analysis; however, their choice about the future relationship of disability and mortality rates has hidden as well as explicit implications, for instance for the projected affordability of private long-term care insurance. Long-term care prices are assumed to increase at a rate a full 45% faster than the general rate of inflation, with tremendous effect on future costs; although this assumption is well supported, it is hard to believe that a market with so much out-of-pocket purchase by consumers will not develop production and service substitutes that will forestall such an increasing divergence of prices from those in the rest of the economy. Modeling of nursing home entry and length of stay is especially difficult, and in this area the model can be seen as a research agenda: effects of trends in income, marital status, insurance, and availability of home care will surely change rates of nursing home use from what they are today, and these relationships could be much better understood.

Despite any quibbles with the model and its predictions, the conclusion stands that the long-term care bill will have grown to staggering proportions by the year 2020. The more interesting question then becomes, who will pay it? In recent years, a variety of solutions to the long-term care crisis have emerged, from sweeping proposals for public financing and delivery to incremental innovations that make it easier for certain groups to finance their own care. Sending these proposals through the reality test of a simulation model is a thought-provoking exercise. It highlights the extent to which the proposals could enhance private ability to pay, thus reducing public dollar inflow; encourage private risk-sharing to change the distribution of burden across the private sector; or increase public spending, thereby spreading the burden of long-term care across the broad base of all taxpayers.

The elderly will be better able to pay for their own long-term care in the future, because of improving pensions and women's work experience, so that tax-deferred long-term care accounts and home equity conversion could enhance private financing; but such programs are simulated to have little impact on the private share of long-term care spending. With public-policy encouragement, private insurance could increase private dollars flowing into long-term care and reduce the number of people facing catastrophic expenditures. It will reduce Medicaid spending insofar as it covers people who would otherwise spend all their income and assets on care, but the simulation predicts only marginal changes, mostly because of predictions about who will find insurance affordable. Life-care communities package housing for the elderly with access to home care, nursing home care, and services like meals, housecleaning, and laundry needed by disabled elderly; the simulation indicates that even if life-care were more widely available, there would be little impact on financing outcomes. The experimental social and health maintenance organization, combining acute health care and some long-term care under a fixed capitation payment, is designed to save resources in acute care by providing home health and nursing home care; again, such organizations even if widespread would have little impact on the division of financing between private sources and the public, means-tested program. Payment to family members is an expensive way to increase our already large supply of family care-giving, and there is little payoff in requiring financial support from adult children. Medicaid spend-down would be less draconian if the individual spending allowance and protected asset level were increased and the spouses of institutionalized persons protected from impoverishment, but the specific policy simulated is shown to cause vast increases in Medicaid spending. Finally, a general public insurance program could spread the cost of long-term care across all taxpayers, entailing a large increase in public spending on long-term care but eliminating impoverishment for elderly nursing home residents.

The simulations imply that private sector initiatives, as defined, will shift few patients from Medicaid, and save few public dollars, at least through the year 2020. On the basis of this finding, the authors support a mixed strategy: they would replace Medicaid with a general public insurance program that covers nursing home stays of longer than two years and buys private long-term care insurance for the poor, with private insurance or individual saving financing the first two years of care.

Despite a list of desiderata for the long-term care of the future, the values that are used to reach this recommendation are not made fully explicit. It appears that to these analysts the problem is Medicaid: the demeaning means test, the burden on state taxpayers, the quality and access problems of a two-tier system, and the spend-down that pauperizes the middle-income recipient. Because the simulation does not identify any private financing solutions that substantially reduce the number of middle-income people ultimately relying on Medicaid, the authors find it necessary to advocate public insurance. However, the deck may be stacked against private solutions: the spiraling rate of inflation in the simulation model makes them unaffordable on the model's terms, and predicted income and pension gains do not work their way to the oldest old, most at risk of nursing home care, by the end year of the simulation. The simulation exercise is saddled by nature with an unrealistic rigidity: it is doubtful that the public, increasingly observing older relatives facing catastrophic expenses at ever-inflating costs, would not express increased demand for fair insurance products, for themselves or for their parents; or that the long-term care delivery system would not respond to private demands with more home care, more efficient nursing home care, and more controlled service packages.

An alternative argument holds that when the needs of some Americans for housing, education, jobs, and health care are so pressing, we cannot justify the use of tax money to fund a public program to preserve the assets of middle-income elderly for the use of heirs. The problem of long-term care is not that needs for care are not being met, but rather that individuals face the risk of catastrophic expense at the end of life and that our public program supplying care for poor elderly has, like public housing programs, offered fewer amenities and lower quality of life than are available to those who can pay. Private long-term care insurance can offer individuals the ability to protect their assets from Medicaid spend-down, and, by insuring that they will be private patients when they need home care or enter nursing homes, to preserve choice about the quality of their lives should they become disabled; choice about quality of life is desirable for everyone, but it may not be consistent to demand it for the elderly disabled before we support it in housing, education, and work life for younger Americans. If fair private insurance is available in the marketplace, it is hard to justify a recommendation that people who would not choose to insure themselves be forced to contribute equivalent tax dollars for public insurance. Instead, reducing market barriers to private long-term care insurance, especially that sold as an employee benefit accumulated over working years, could combine with Medicaid reforms to provide decent, dignified care for all.

By laying out the costs, benefits, and other implications of their preferred option and its alternatives, Rivlin and Wiener set a high standard for others considering long-term care issues. All must clarify the extent to which their judgments about the course to follow involve unknowns that should be studied, like nursing home use patterns; future uncertainties, like long-term care inflation and the incidence of disability, that must be monitored; or policy values.

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AIDS and Communal Values

Private Acts, Social Consequences. AIDS and the Politics of Public Health. RONALD BAYER. Free Press (Macmillan), New York, 1989. vi, 282 pp. $22.95.

Private Acts, Social Consequences is one of the first books on the AIDS crisis to confront the central philosophical issues raised by the epidemic. To date most authors writing on the subject have focused on the vacillation of the Reagan Administration or the impact of the epidemic on one city, San Francisco. Now Bayer gives us much-needed perspective on the epidemic by examining it through the historical, political, and philosophical conflicts of public health in the United States. Bayer, a faculty member of the Columbia School of Public Health, was for a number of years affiliated with the Hastings Center and led projects on public health and civil liberties, including a project on the AIDS epidemic. His detailed knowledge of the many facets of the epidemic, and of the profound changes it is working on many American social and health care institutions, shows in the book.

Beginning with an introductory chapter that lays out the central theme of the book, the conflict between individual rights and community welfare, Bayer examines in successive chapters the controversies over closing the bathhouses in San Francisco and New York City, safeguarding the blood supply, screening for HIV seropositivity, and the associated issues of making tests mandatory and reporting of results, quarantine and isolation, and finally education.

Bayer's analysis of the bathhouse contro-