Aftercare

The second major sector which is likely to offset significantly the use of inpatient hospital services is health and social services for post-hospital and chronic disease care of the aged. This sector, which encompasses a range of residential, outpatient, and in-home services, is the most rapidly growing part of the health care system, and it is as intensely competitive as the hospital sector. Though the conceptual focus of this book has been the impact of changing patterns of health care delivery on the market for hospital services, the market for aftercare services is the focus of an equally lively debate regarding the economic and human merits of alternative approaches to meeting the needs of the elderly.

Those who believe that Medicare resolved the problem of caring for the nation's elderly will be disabused rapidly of this notion by examining the evolution of aftercare services under Medicare. While the enactment of Medicare provided comprehensive coverage for treatment of acute illness among the elderly, it left a legacy of confusion and fragmentation in dealing with chronic illness and medical and social problems which accompany aging. As Anne Somers commented:

> Medicare's obvious deficits with respect to long term care and the chronically ill are not the result of sloppy legislation or poor administration. The program simply was not designed with chronic illness in mind. We now know that this is the major unmet health need of older people, but we are less sure how to correct the situation.[1]

In this chapter, we examine the growing demand for health and social services to the elderly and some of the competitive implications of various strategies for meeting their needs for hospitals and other health care providers.

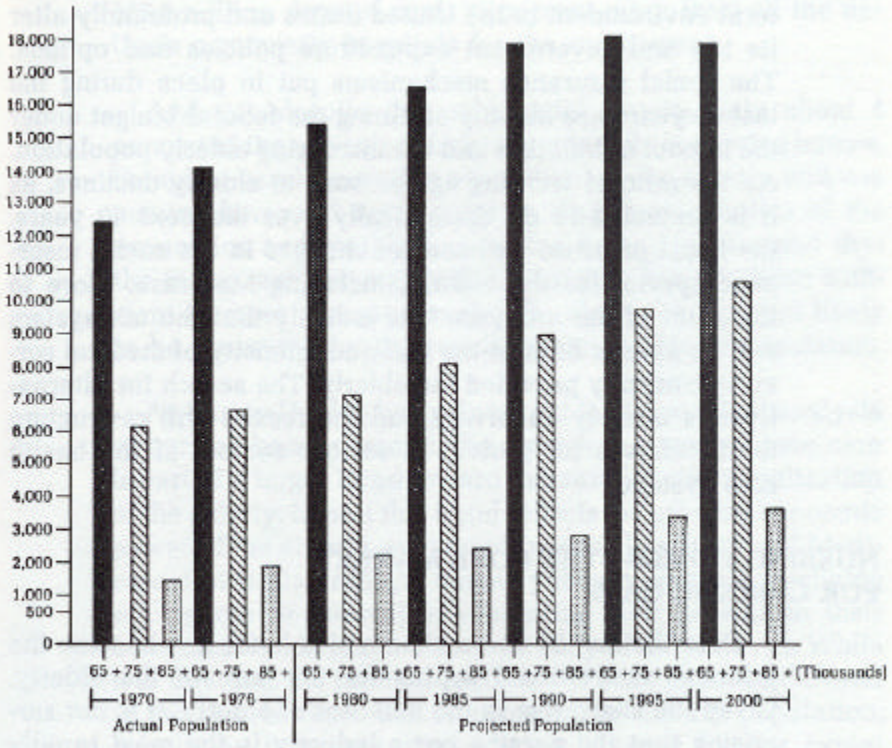
HEALTH CARE AND THE ELDERLY POPULATION

In marketing parlance, the elderly are the "heavy half" of the health care market. Though the nations' elderly amounted to only *10.9* percent of the population in *1978,* they consumed nearly one *third (29.4* percent) of the nation's health resources.[2] Per capita hospital expenditures for the elderly were *$869* in *1978,* more than double the *$370* per capita spent on persons aged *19* to *64,* and eight times the expenditures for people aged *18* and under. The elderly have a per capita physician's office visit rate of *6.3* per year, 50 percent greater than for age groups under age *55.* They also account for *86* percent of the nation's nursing home expenditures.

Within the elderly population, the concentration of health service expenditures increases as a person nears death. Over 32 percent of all Medicare expenditures are made in the last year of life for those persons over *85* years of age.[3] While persons over *85* accounted for only about 9 percent of the over *65* population in *1978,* they consumed six times the amount of hospital days per capita as persons under *65* and *50* percent more than all persons over *65.*[4] Furthermore, this population of very elderly persons accounted for *35* percent of all nursing home days of care.[5]

In light of impending population growth among elderly groups, their current rate of consumption of health services poses a major fiscal and human problem for the U.S. health care system (see Figure *3-1).* The number of Americans over *65* years of age has increased from *4* million in *1900* to 24.5 million in 1980 and will more than double again, to an estimated 55 million persons, over the next 50 years. The elderly population is currently increasing at 500,000 persons per year.[6]

FIGURE 3–1



Note: 65+ means 65–74; 75+ means 75–84.
Source: *Health: United States 1978*, Washington: U.S. Department of Health and Human Services, p. 148.

Within this group, the population aged 75 and over is expected to increase even more rapidly, reflecting the fruits of economic prosperity, advances in medical science, and the consequent improvement in health status of U.S. citizens. Those persons over 75 constitute 38 percent of the elderly population at present and those over 85, 9 percent. Those proportions within the elderly population are expected to increase to 45 and 12 percent respectively, by the end of the century. By the time the baby boom generation reaches the 75 plus threshold, it will constitute more than half of the elderly population.

These population shifts will reshape the political and cultural environment in the United States and profoundly alter its tax and government expenditure policies and options. The social insurance mechanisms put in place during the last 40 years are already straining the federal budget under the impact of inflation and the increasing elderly population. As the ratio of working age persons to elderly declines, as it is projected to do dramatically over the next 40 years, the fiscal pressure will compel changes in the social insurance system for the elderly, including Medicare. More to the point of our analysis, it is unlikely that the tax system will be able to finance the mix and intensity of medical services currently provided the elderly. The search for alternatives is already underway and the results will restructure the incentives for growth in various sectors of the health care system.

NURSING HOMES-THE CORE MARKET FOR CHRONIC CARE

Over the last 30 years, the nursing home has become the principal institutional setting for the care of the elderly. Given the sharp rise in the numbers of elderly, it is not surprising that the nursing home industry is the most rapidly growing part of the health care system. As can be seen from Figure 3-2, nursing home expenditures in the United States grew from $187 million in 1950 to $17.8 billion in 1979. Since 1965 the share of the nation's health care outlays consumed by nursing home care has almost doubled, from 4.9 to 8.4 percent. During the 1970s nursing home expenditures grew at 19.6 percent annual rate, compared to a 12.5 percent rate for hospital expenditures.[7] The number of nursing home beds in the United States increased from 568,500 in 1963 to more than *1.4* million in *1979.* In *1978* nursing homes generated *452.8* million days of care, *74* percent more than all the nation's community hospitals for the same year.[8]

FIGURE 3–2
National health care expenditures by types and percent of total, calendar years 1940–1979 ($ millions)

	1940		1950		1965		1979	
Physician Services ..	$ 973	24.4%	$2,747	21.7%	$ 8,473	20.2%	$40,599	19.1%
Hospitals.....	$1,011	25.4%	$3,851	30.4%	$13,885	33.1%	$85,342	40.2%
Nursing Home Care	$ 33	0.8%	$ 187	1.5%	$ 2,072	4.9%	$17,807	8.4%

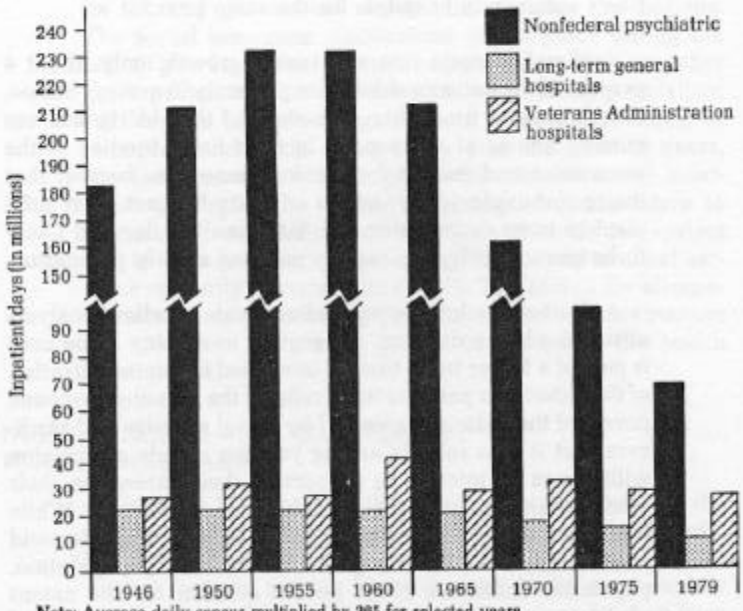
Source: Robert Gibson, "National Health Expenditures, 1979," *Health Care Financing Review* 2, no. 1 (Summer 1980), pp. 21, 22.

And yet, despite this substantial growth, only about *4* percent of the nation's elderly are presently in nursing homes, though several times this percentage of the elderly will use nursing homes at some point in their lives. Studies of the economics and market for nursing home care suggest that the recent explosive growth in capacity has not been sufficient to meet *current* demand, let alone the demand likely to be generated by the rapidly growing elderly population.

As Burton Dunlop has pointed out in his excellent analysis of nursing home demand, the growth in nursing home care is part of a larger trend toward increased institutionalization of the elderly. In part this trend reflects the growing economic power of the elderly, supported by social security and Medicare. But it also reflects among younger people a declining willingness or interest in supporting their parents in their own households, given the availability of alternatives. While it is true that the primary predictor of nursing home demand is the size of the older segment of the elderly population, population increases alone do not account for the extent of the growth in ins titutionalization.[9] While the number of elderly rose by *21* percent between *1960* to *1970,* the number of institutionalized elderly rose by almost triple that rate*58* percent. And the number of elderly in nursing homes doubled during *the* same decade, accounting for the vast majority of growth in institutionalization during the decade.[10]

The growth in nursing home care occurred at the expense of alternative settings for long-term or chronic care. Figure 3-3 shows postwar trends in the utilization of several of these alternative modes of care for the long-term patient. By *1979* days of care in mental institutions (nonfederal) had declined by more than *72* percent from the *1955* peak. Care in long-term general hospitals declined by over *46* percent during the same period. Care in the nation's veterans hospitals has declined by one third from the *1960* peak.

FIGURE 3–3
Inpatient days by type



Note: Average daily census multiplied by 365 for selected years.
Source: American Hospital Association, *Guide to the Health Care Field* (Chicago: American Hospital Association, 1980). Veterans Administration Hospitals, *Annual Report* (Washington, D.C.: U.S. Government Printing Office, selected years).

A number of factors governed the extent of the trade-off between nursing home care and these alternative modes of rendering long-term or chronic care. The movement toward "deinstitutionalization" of the elderly in mental institutions for example, reflected a number of convergent influences. They included advances in drug therapy, changing medical attitudes toward the appropriate treatment of senility, aggressive development of community based treatment programs, and changing fiscal incentives for state governments, principally as a result of the advent of Medicaid. William Pollak has estimated that 25 percent of the growth in nursing homes utilization between 1960 and 1970 can be attributed to diversion to nursing homes of patients either in or destined for mental hospitals.[11]

In the case of community hospitals, an increasing focus upon acute care led to a de-emphasis on long-term care. In the last 25 years there has been a substantial shifting of demand for long-term care of the impaired elderly from hospitals to nursing homes. Dunlop observed:

> Until relatively recently, hospitals were often used to care for impaired and usually indigent elderly on a long-term basis, especially if they required any amount of nursing care. Some hospitals reserved special wings for long-term care, but this seems a largely post World War II development. Use was especially heavy for public charges in county hospitals. By the beginning of the study period (1960-1970), however, specialization of hospitals for acute care (with all its implications for facility prestige and rapidly rising costs) was nearly complete. This created increasing pressure to provide for the chronically ill or functionally impaired in specialized long-term care settings, principally nursing homes.[12]

As will be seen below in our discussion of Medicare and Medicaid impact on long-term care demand, one of the policy thrusts of Medicare was to encourage transfer of individuals recuperating from illnesses from hospitals to extended care facilities (ECFs). The impact of these

shifts in hospital policy and insurance systems can be seen in the declining length of hospital stay during this same period of explosive nursing home growth. The length of stay in the nation's nonfederal short-term hospitals declined from 9.1 days in 1946 to 7.6 days in 1979, while the length of stay in public hospitals (nonfederal) declined even more dramatically, from 11.4 days to 7.4 days during the same period.[13]

Dunlop speculates that there was also some substitution of nursing home care for certain types of group care, including sheltered care and homes for the aged, as well as for residential living in unlicensed boarding homes, houses, and related facilities. The extent of this substitution is extremely difficult to document, though Dunlop pointed to a decline in the number of institutionalized elderly living in what the U.S. Census Bureau calls "group quarters"-from 40.5 percent in 1940 to only 12.3 percent in 1970. Dunlop points out, however, that much of this decline could also be attributed to the increased economic viability of independent living under social security. [14]

Medicaid and Medicare influence on the nursing home market

The impact of these two federal health care entitlement programs on nursing home demand is poorly understood among those outside the long-term care field. Few people realize, for example, that Medicare, the nation's entitlement health program for the elderly, finances only a minuscule portion of the nation's nursing home services (only about 3 percent in *1979),* while Medicaid, the nation's entitlement program for the categorically needy, finances almost *half* of these services (Figure 3-4). In *1978* only *8.6* million days of nursing home care were covered under Medicare, *56* percent fewer than in *1968.*[15]

FIGURE 3–4
Nursing home revenues, 1965 and 1979 ($ in millions)

	1965	Percent of total	1979	Percent of total
Total nursing home care	2,072	—	17,807	—
Consumers-direct (self-pay)	1,337	64.5	7,481	42.0
Private insurance	2	0.1	117	0.7
Other private programs	21	1.0	107	0.6
Medicare	—	—	373	2.1
Medicaid	—	—	8,796	49.4
Other government programs	711	34.3	934	5.3

Source: Robert Gibson, "National Health Expenditures: 1979," *Health Care Financing Review,* Summer 1980, pp. 29, 32.

There is virtually no private insurance coverage for nursing home services at the present time. In *1979,* private insurance accounted for less than 1 percent of nursing home expenditures. The balance of financing for nursing home care is from the "self-pay" patient, as can be seen from Figure 3-4. When asked why there is no private insurance market for long-term care, industry experts point out that it simply has never been needed since it is so easy to enroll patients in the Medicaid program. The principal technique is to transfer the assets of the elderly to children or other relatives. Since financial resources of the children of the elderly are not considered in determining the elderly person's eligibility for Medicaid, the elderly will generally "spend down" remaining resources and become covered by Medicaid. Given the rapidly deteriorating outlook

for Medicaid funding, the Medicaid role as the residual insurance mechanism for longterm care seems to be ripe for re-examination. Private insurance for supplemental nursing home coverage, and ultimately for the full cost of care, will come to be demanded by the nursing home industry and by consumers threatened with diminished access to long-term care as Medicaid funding is curtailed.

The relative roles of Medicare and Medicaid in nursing home financing can be explained by reviewing the legislative history of these programs. The drafters of the Medicare legislation viewed the nursing home as a lower cost extension of the hospital for recuperation of the elderly patient. The thrust of the Medicare Extended Care Facility (ECF) program was thus to link Medicare funding of long-term care benefits to particular hospitalizations. Specifically, the legislation mandated a minimum three-day hospital stay prior to admission to a long-term care facility, certification of the medical need for admission by the patient's physician, and that the admission to the nursing facility take place no more than 14 days after discharge from the hospital. Coverage was limited to 100 days of long-term care per illness, with copayment by the patient after 20 days, presumably to encourage patients not to use the full 100 days.

During 1969, in an apparent response to the increased program costs of nursing home care under Medicare, the Department of Health and Human Services tightened eligibility standards by limiting care only to those individuals who had "rehabilitative" potential-excluding many of the chronically ill as well as the preterminally and terminally ill. The 1969 regulations also tightened the definition of services for which the program would pay, as well as the costs which it would reimburse as part of "reasonable cost" of care. These redefinitions led to retroactive denials of reimbursement for Medicare services already rendered, infuriating the nursing home industry and triggering massive provider defections from the program.

The result of restricting nursing home reimbursement under Medicare was to push the elderly into the Medicaid program, where costs were shared with the various state governments participating in the program. Thus the federal government avoided growing nursing home costs by shifting them onto state governments. Because Medicaid definitions of covered services were much broader than those of Medicare, many of the elderly who met income eligibility criteria for Medicaid became eligible for Medicaid coverage of their nursing home benefits.

As Dunlop points out, however, enactment of Medicaid did not result in large new populations becoming eligible for government-financed long-term care. The primary reason for this is that preceding programs under social security the Old Age Assistance and Aid to the Aged Blind and Disabled Programs-already covered nursing home care. These programs, and related state-funded medical assistance programs, accounted for 34.4 percent of nursing home revenues in 1965, the year prior to implementation of Medicaid. According to Dunlop, "except in a very few states, the adoption of Medicaid seems to have had very little effect on the relative access of the population to nursing home care and hence on demand through the raising of income eligibility levels."[16] Rather, population growth and shifting patterns of demand for services, combined with more generous reimbursement, helped accelerate growth in the nursing home bed complement and population.

However, Medicare and Medicaid appeared to have a major impact on two key features of the nursing home-quality and the supply of beds. With respect to quality, the federal government began to require compliance with life safety and staffing standards as a condition of participation in the program. This, in turn, led to stricter state licensing laws for nursing homes and resulted in

a dramatic upgrading in the quality of nursing home facilities. Dunlop illustrated the difference between pre- and post-Medicare /Medicaid periods as follows:

> In 1964, the typical nursing home was an older, wooden-frame two- or three-story converted house, containing perhaps forty beds, owned and operated by a husband and wife, with an LPN supervising staff activities during the day shift. Today, the Life Safety Code with its expensive provisions and the information and reporting requirements for participation in federal funding programs-principally Medicaid-has produced typically a single-story, fire-resistive facility of sixty beds frequently owned by a corporation or partnership of investors and often managed by a salaried nursing home administrator. It houses a larger proportion of sicker patients and employs RNs and/or LPNs supervising staff functions on all shifts.[17]

Of course, these standards also led to large increases in the unit costs of care (that is, beyond inflation) and is believed to have encouraged the entry of investor-owned firms into the nursing home management field.

On the reimbursement side, the introduction of the two programs established the legitimacy of cost-related reimbursement, which was the basis for Medicare reimbursement. For Medicaid, states were encouraged to move away from a flat, state-wide rate set independent of particular facility costs toward a facility-dependent rate. In most cases, this was open-ended "cost reimbursement," with a maximum level specified. Of course, the maxima became the equivalent of a fixed rate as facility costs moved upward rapidly toward them. In general, the implementation of Medicaid in states was linked to an increase in the unit reimbursement for nursing home services.[18]

The relationship of these two programs to the expansion of nursing home bed supply is elusive and confusing. Dunlop points out that the implementation of Medicare and Medicaid did not lead immediately to expanded nursing home bed complements. Rather, growth in the bed complement accelerated during the early *1960s,* and actually *slowed* in the first full four years of Medicaid and Medicare. From *1963* to *1966,* the bed supply grew at an annual rate of *10.7* percent. During *1967-70,* the first full four years of Medicare, the rate slowed by half, to an annual growth rate of 5.4 percent. From *1971* to *1973* the rate accelerated to *8.3* percent, and subsided again slightly during the *1973-79* period.[19] The reduced growth rate in the first four years may have reflected industry concerns about the stability of the federal commitment to funding long-term care.

The relationship of Medicaid funding levels for nursing home care to the supply of beds is a subject of considerable controversy. Because of the near monopsonistic position of Medicaid in the nursing home market, William 1. Scanlon believes that the rate paid by Medicaid is the principal rate limiter in the growth of nursing home supply. Scanlon conducted an extensive empirical analysis of the market for nursing home services using data from two years, *1969* and *1973.* He performed several tests of hypotheses related to the presence of excess demand for nursing home services and demonstrated "the strong likelihood of considerable excess demand for nursing home care."[20]

According to Scanlon, the market for nursing home care is divided into self-pay and Medicaid segments. There are powerful incentives for nursing home operators to seek out the self-pay patient, who pays higher rates, and to queue the Medicaid patient. State governments are compelled to trade off rate increases for nursing homes against other services, and more recently against tax relief, and have thus restrained rates paid to nursing homes. If Scanlon's analysis is

correct, the impact of increasing Medicaid rates for nursing home care could be multiplicative, not merely additive, since the supply of beds would expand in response.

Critics of the nursing home industry have pointed out that nursing home operators have nevertheless been able to generate substantial return on equity while relying on Medicaid reimbursement for half of their income and they suggest that the nursing home industry could not have attracted the capital to virtually double its bed complement if it were losing money on more than half its patients. At least one prominent analysis has suggested that expansion and profitability in the nursing home field has occurred at the explicit expense of quality care. Bruce Vladeck in his Unloving Care suggests that for-profit nursing homes operations have traded off profits against the amenities of care, given the low reimbursement rates provided by Medicaid and the inattentive monitoring by licensing agencies.[21]

Health planners and state budget officials believe that nursing home demand will simply expand with supply and, through Certificate of Need and rate decisions, have been unwilling to encourage further growth in capacity. Nursing home occupancy rates approaching 90 percent nationally, and exceeding this level in large states like Illinois, certainly suggest, however, that there is no excess capacity in the industry at the present time.

The controversy over the adequacy of supply of nursing home services is exacerbated by evidence that large amounts of inpatient expense to the Medicaid and Medicare programs are incurred by patients ready to be discharged from hospitals but unable to be placed. The principal reasons for this relate to nursing home industry unwillingness to deal with Medicare red tape and the lengthening queue for Medicaid recipients. Several studies in Massachusetts found that more than 1,000 patients in Massachusetts hospitals were awaiting nursing home placement on any given day. Estimates of hospital costs incurred annually ranged up to $20 million for the state.[22] No nationwide estimates of the amount of such hospitalization are available, though anecdotal evidence suggests the costs could amount to as much as $100 million annually.

No one really knows what the universe of need for nursing home care is. A General Accounting Office report to Congress in 1978 suggested that nearly 3 million elderly needed nursing home care but were not receiving it.[23] This number is more than double that of individuals currently in nursing homes. Various experts in the field of gerontology place the number of elderly having some form of handicap or impairment which impedes independent living at between 14 and 17 percent of the total population of elderly (a range of between 3.4 and 4.2 million people).

Proponents of alternatives to nursing home care point out that people in nursing homes spend only 2 percent of their waking hours receiving direct medical or nursing treatment.[24] They cite studies showing that only 37 percent of a large population of nursing home residents needed full time care and that an additional 26 percent needed only "supervised living."[25] The issue of the continuum of care for chronic illness will be explored below. Suffice it to say that there appears to be considerable demand for some type of care of the impaired aged, a demand which will grow with the increasing elderly population. Proponents of various modes of care believe this translates into demand for the services their organizations provide.

The proprietary presence in the nursing home industry

Unlike the hospital industry, for-profit providers of care dominate the nursing home industry. As of 1977, the latest year for which this type of data is available, 76.8 percent of the nursing

home beds, 69.3 percent of the establishments, and 68.2 percent of the patients in nursing homes were in proprietary facilities.[26] By comparison, only about 60 percent of nursing home residents were in proprietary facilities in 1964.[27] Prior to the enactment of Medicaid, the vast majority of these proprietary facilities were of the type described above-small, family run operations housed in converted residences. However, since the middle 1960s, investor-owned firms have moved into nursing home administration. By 1979, these firms have grown in market position to an estimated 12 percent of all nursing home beds, a percentage roughly comparable to that of the management firms in the hospital industry. The total number of nursing home beds managed by these firms grew from approximately 149,000 in 1978 to almost 169,000 in 1979.[28] Perhaps because of the proprietary influence in the industry, it has been unusually susceptible to charges of profiteering and exploitation of patients. There were major nursing home scandals in New York State and elsewhere in the mid-1970s which damaged the industry's reputation.

In his analysis of nursing home efficiency, Michael Koetting found that, on the average, proprietary homes were more likely to be of lower quality than non-profit facilities and observed that the last decade has illustrated abundantly that proprietary institutions often have lower standards for appropriate levels of service provision and are much more likely to abuse existing procedures.[29]

However, research findings suggest that proprietary providers may well be more efficient than their nonprofit counterparts. Koetting found that "proprietary nursing homes are more efficient than nonprofit homes. Specifically, at any given quality level, proprietaries are less expensive. This is true even if allowance is made for a return on investment in proprietaries."[30] No data exists, however, on the relative efficiency of multi-unit versus freestanding for-profit homes.

High capital costs and cash flow difficulties from Medicaid and Medicare may be two major reasons why the investor-owned firms will continue to grow as a percentage of all nursing home operators. Like their hospital management counterparts, these firms have access to credit and, in some cases, equity markets which their nonprofit competitors do not. Koetting points out that "it does not seem likely that there is sufficient capital or management expertise in the nonprofit sector to expand to meet the rising demand for nursing home care."[31]

As in the hospital industry, the most rapid mode of expansion of the firms in the immediate future may be through management contracting or leasing rather than through direct ownership. Beds under contracts by management firms rose 28 percent from 1978 to 1979, and those under lease by 20 percent compared to a 5 percent growth in owned beds during the same period.[32]

Several of the large hospital management firms are developing a major presence in nursing homes as well. National Medical Enterprises acquired the third largest nursing home operator in the country, Hillhaven Corporation, in early 1980. Both Hospital Affiliates International, a subsidiary of the INA Corporation, and American Medical International have large nursing home operations as well. The nursing home industry giant is ARA Services, Incorporated, which controlled more than 31,000 beds in 1979 through four divisions.[33]

HOME HEALTH CARE AND THE ALTERNATIVES TO INSTITUTIONAL CARE

Unlike the acute end of the health care system, where patient care is mediated by the patient's physician, the chronic care end suffers from the lack of informed mediation between the patient and the system. As Scanlon points out in his analysis of the nursing home market, demand for

longterm care and chronic care is not derived, but rather direct, demand. The patient and family are left to seek care amid a confusing array of possible alternatives. The confusion is heightened by shifting and inconsistent guidelines for eligibility and reimbursement for many services, and by a serious lack of information about the range of costs and types of care available.

At this point the principal competition of the nursing home is the burgeoning field of home health care services. Home health care falls along the continuum of care between the medical and custodial care of the nursing home and the social services provided by traditional social agencies. The medical services which may be provided in the home by a visiting nurse or aide including nursing; medical assistance; medical social work; physical, occupational, and speech therapy; and medical supplies and equipment. The nonmedical services may include homemaker assistance, meals on wheels, visiting, and telephone reassurance, and escort and chore services.

The split between medical and nonmedical services is artificial, since the inability of the patient to perform any number of functions-including housekeeping, transportation to and from therapy in a hospital, and self-medication with prescription drugs, to list only a few examples-may necessitate either prolonged hospitalization or institutional care in a nursing home. Yet the split becomes critically important since the rigid funding categories of federal health and social services programs will permit only certain programs to pay for certain forms of home care.

Until the fall of 1980, when Medicare program guidelines for home health care were liberalized, such home health benefits as nursing home benefits were linked to a minimum 3-day hospital stay, and were limited to 60 visits per illness. Medicare limited the provision on nonskilled (e.g., non-nursing services) by providing them only where skilled in-home nursing care was also provided. Conversely, the Title XX Social Services program under social security will reimburse only for nonskilled services. It takes prodigious energy and savvy to be able to coordinate funding from these various sources to provide enough of the right kinds of home care to individuals who need it.

In part because of the fragmentation at the federal and state levels, data on the amount and nature of home health services currently being provided to U.S. citizens is almost impossible to obtain. An Arthur Young study in mid-1980 estimated the size of the home health market to be $2.5 billion .[34] Data on government funding of home services during fiscal year 1977 revealed total spending of approximately $1 billion from the three programs involved. Medicare and Medicaid financed home care for approximately 738,000 persons while Title XX paid for services for more than 1.6 million. The two groups may overlap considerably. Trend data on expenditures for Medicaid and Medicare show major growth in funding during the middle 1970s.

Medicare outlays for home health services have grown from $56.8 million in calendar year 1971 to $458 million in fiscal year 1977. At the time of this writing, fiscal 1979 outlays were estimated to be approximately $634 million. If this estimate is accurate, Medicare spent almost twice as much on home health care as it did on nursing home services during fiscal 1979. There is apparently considerable room for further expansion.

Research findings on the cost implications of home care have established that it can be important in forestalling hospitalization for certain patients as well as in reducing the length of hospitalization. Studies have been inconclusive on the relative cost effectiveness of home care relative to nursing home care. In his review of research literature on this point, John Hammond concluded:

From the standpoint of third party underwriters, home health care is indeed less expensive than extended hospitalization. The limited number of articles available for review dictates caution in drawing a similar conclusion regarding the effect of home care on unnecessary hospital admissions. Available information indicates that the costs of home health services for patients requiring the same level of care are roughly equivalent to the cost of nursing home care.[35]

A problem with many cost studies may be the failure to factor in the cost of self care in the home. Costs to the *patient* (as opposed to the insurer) of in-home versus nursing home services can only be assessed if total living costs, not merely medical costs, are subjected to comparisons.

In his somewhat more thorough review of the literature on home health care costs and potential substitution for more costly modes of care, Avedis Donabedian is considerably more cautious than Hammond. In one study he reported that:

> [H]ome care was successful in managing the patients' heart disease, and was also instrumental in uncovering additional illness for which hospital care was necessary. Thus, the substitutive effect of the home care benefit was more than offset by the "discovery effect" of these same benefits, at least in this group of elderly and seriously ill patients. Once again, we find confirmation of the aphorism that "a little medical care breeds more medical care." [36]

Donabedian found confirmation of this effect in another study of cardiac patients as well as in two carefully controlled studies of attitudes of patients being discharged from chronic disease hospitals. He speculates that this discovery effect may be less pronounced for less seriously ill patients with self-limiting conditions or for less intensive home care. To the extent that the discovery effect prevails, cost advantages of home care could be reduced or even eliminated. These studies are part of the reason why insurers have moved cautiously in extending home care benefits.

Not a great deal is known about the competitors in this rapidly growing field. Data gathered from the Medicare program in Health and Human Services showed evidence of trends among competing providers of home health services. These can be seen in Figure 3-5.

FIGURE 3–5
Participating Home Health Agencies, June 30, 1971–1980

Type	1971	1972	1973	1974	1975	1976	1980
Visiting nurses association	559	534	540	531	525	515	513
Combined government and voluntary	67	59	54	47	46	42	53
Official health agency	1,311	1,277	1,259	1,257	1,228	1,218	1,284
Rehabilitation based	12	11	11	10	9	10	6
Hospital based	209	219	244	267	273	280	335
Skilled nursing facility based	10	7	7	6	5	5	9
Proprietary	50	42	41	39	47	68	184
Other*	66	73	55	91	109	223	470
Total	2,284	2,222	2,211	2,248	2,242	2,361	2,854

* A majority of agencies in this category are private nonprofit.

Source: The information was made available by the Bureau of Health Insurance, Social Security Administration, HEW, to the Council of Home Health Agencies and Community Health Services, National League for Nursing. It appeared in *Community Home Health News*, December 1976, p. 3; Reprinted by permission from the National League of Nursing. 1980 data obtained from "Home Health: An Industry Composite" (Chicago: Arthur Young & Company 1980), p. 7.

Specifically, the number of participating Visiting Nurse Association agencies, the traditional provider of home care, declined by about 8 percent during the ten-year reporting period while the number of hospital-based programs participating in Medicare increased by 60 percent and the proprietary agencies by 268 percent. The number of proprietary providers had risen to 184 by the 1980 Arthur Young & Company report. This number underrepresents the actual number of proprietary home health providers. Until the 1980 program changes, federal statutes required proprietary providers to be licensed by a state agency in order to receive Medicare reimbursement. Since only 24 states both license home health agencies and permit proprietary operations, agencies in the remaining 26 states could not be reimbursed by Medicare. The elimination of the state licensure /certification requirement by federal law will substantially increase not only the number of participating agencies, but broaden access to home care in many states.

The number of hospital-based programs reported by Medicare may understate the actual number of hospital programs. By 1980 almost 350 hospitals offered home care services under Medicare, an increase of almost one third in four years. Total participating agencies had increased to more than 2,800. The Arthur Young study estimated that an additional 2,000 agencies offered home care services but, for a number of reasons, did not participate in Medicare. [37]

Though the growth of home health care services represents a potentially positive development from a cost standpoint, there may be other benefits to avoiding institutionalization which are difficult to quantify. These benefits include the psychological advantages accruing to a person who is supported in his or her effort to remain independent, and assistance to the families of elderly or seriously ill individuals who may themselves lack the medical or other capacity to maintain their family member at home. There is support in the literature for the efficacy of home care. Wan, Weissert and Livieratos reported that the use of day care and homemaker services can help the disabled elderly to sustain, if not to improve, their functioning. More specifically, the treatment modalities, day care and homemaker services, had an effect on the survivorship of patients, a positive effect on physical and mental well-being, and a limited but positive effect on social activity. [38]

The hidden agenda of policymakers who advocate expansion of home care benefits may be to strengthen the ability of elderly persons' families to care for them directly rather than placing them in nursing homes. The presence of nurses and home care aides in the home on a regular basis frees other family members for work or schooling while keeping the elderly person in the family environment. Nursing home operators have begun reinforcing home care by offering something called "respite care"-short-term institutionalization to permit family members to take vacations or do other things they would be unable to do with the elderly person at home. This is an excellent marketing tactic since it establishes the home's credibility for later, longer term institutional care. By reinforcing the family through home care, policymakers hope that long-term institutionalization can be avoided later.

Policymakers and social services advocates believe that home care represents an alternative to further major expansion of nursing home services as well as to costly hospitalization. The 1980 liberalization of benefits under Medicare is likely to expand care in this sector more rapidly than nursing home care over the next several years.

THE HOSPICE CONCEPT

Yet another alternative mode of providing care has emerged specifically for treatment of the terminally ill. The current organization of health care does not accommodate easily to the needs of the terminally ill, since it is organized, for the most part, around a high technology assault on acute illness. As initially developed by health care pioneer Dr. Cicely Saunders of St. Christopher's Hospice in London, the hospice concept involved providing spiritual and psychosocial help for the patient as well as palliative care to relieve the pain of terminal illness (primarily, but not exclusively, cancer), and bereavement counseling for the family. The approach is multidisciplinary, involving physicians, nursing and social services personnel, and priests and chaplains. Care is intended to be continuous, in contrast to the episodic course of treatment for most illness.

The movement grew rapidly during the 1970s. While only 3 hospices were in existence in the United States in 1975, there were 78 in operation only three years later, with more than 200 more in some stage of planning. The concept is not specific to a particular institutional setting. There are at least five possible ways of providing hospice care:

1. Hospice care in the home.
2. Hospice teams in hospitals.
3. Palliative care units in hospitals.
4. Hospital affiliated hospice programs.
5. Freestanding, autonomous hospices. [39]

The link to a hospital and to a primary physician, usually an oncologist (cancer specialist) is essential. Yet, hospice care is not necessarily an offset to inpatient hospital care as much as a different way of providing care. Thus it is impossible to speculate about the potential impact of this movement upon the demand for inpatient hospital services, other than to suggest that some people who die in hospitals might, for reasons of personal adjustment and concern for the impact on their families, choose to die at home or in other more supportive settings.

The key factor in determining the growth of this movement will be decisions by the major insurers including, ultimately, Medicare and Medicaid, concerning the insurability of hospice care. A number of pilot programs are being conducted by Blue Cross which will determine its future policy regarding reimbursement for hospice care. [40] At least one published study from the Blue Cross investigations does appear to support the cost effectiveness of a hospice program which heavily emphasized home care. [41] Until the results are in, acceptance of these programs as part of health insurance benefits packages is going to be cautious. Two large Blue Cross-insured industrial employers, General Electric and Westinghouse, did conclude contracts with Blue Cross to cover hospice benefits beginning in 1980. [42] It will take several years before the results of the debate regarding the merits of this new form of care are reflected in incentives to develop such services, but the concept appears to be promising.

THE PROBLEM OF COORDINATION

As mentioned above, the physician's responsibility for mediating aftercare for the patient is either attenuated or nonexistent. The declining role of the physician in managing chronic care and the disabilities associated with aging leaves the patient and his or her family essentially on its own in dealing with the variety of options available, except where the family is indigent or otherwise has access to a social caseworker.

The alternatives array themselves along a continuum of long-term care which runs from the institutional setting through a variety of ambulatory services to the home. The institution may be a hospital or a nursing home. Health policymakers and health care entrepreneurs are engaged in a lively debate, which has been underway since before the inception of Medicare and Medicaid, over the merits of choosing care at various points along this continuum. How services are used and in what mixture and for which problems and under whose supervision-these problems have yet to be solved adequately.

A solution of sorts appears to be in the making, however, in the form of fixed restraints. Medicaid and perhaps ultimately Medicare as well appear headed for periods of restrained growth. Thus, the resources devoted to long-term care may be capped by the necessity of restraining overall costs of these programs. This restraint will compel tradeoffs not only between inpatient care and aftercare (which is much less expensive), but between the various forms of aftercare, which vary in cost (at least to the government). The search for "brokers" may extend beyond the acute care setting into aftercare as well.

A promising experiment which interposed a caring "honest broker" between providers of long-term care and elderly clients has been conducted in Connecticut to address the cost and access problems identified above. Triage Incorporated is a social agency supported by a demonstration grant from the Health Care Financing Administration (HCFA). [43] The agency serves the needs of elderly persons in a seven-town region of central Connecticut. Triage conducts an assessment of each elderly person and arranges for services needed *and* takes responsibility for purchasing them. The assessment is conducted by a team consisting of a nurse clinician and a social worker. HCFA granted Medicare waivers to reimburse through Triage for a variety of services not conventionally reimbursed by the program, including many home care social services, (homemaker, meals on wheels), intermediate care (institutional), legal services, and mental health counseling.

Triage was successful in navigating the range of available services for its clients. For *1,747* clients served in fiscal year *1978*, Triage was able to save *81,275* long-term care days, at a net savings (net of Triage expenses) of *$1.6* million, even including the cost of waivered services. That is, through the judicious use of alternative, non-institutional services, Triage was able to avoid *46.5* days of nursing home care per client per year, at an average annual savings to Medicare of almost $1,000 per elderly person. This amount represented an approximate 20 percent savings below costs which would have been incurred without the coordination. A key to the program is combining coordination of the service with payment for it. The increased clout given the coordinating agency was an important reason for the efficiency of the project. Decision-making about patient needs was placed in the hands of a concerned but fiscally responsible intermediary other than the provider of care.

THE ROLE OF THE HOSPITAL IN THE AFTERCARE MARKET

As discussed above, hospitals have been getting out of the business of aftercare. In the last 25 years the long-term care patient day production of general hospitals has declined by almost 50 percent. [44] The withdrawal of the hospital from aftercare, in a period of rapid specialization of chronic and long-term care, has helped create some of the vacuum discussed above. Hospitals are intimately linked to the aftercare system through their social services departments. Caught between the pressures of professional standards review organizations to reduce the length of stay

for Medicare patients and the tightness of nursing home bed supply, many hospitals are, perhaps against their wills, providing the missing coordination through their placement policies.

In an area growing and diversifying as rapidly as the aftercare market, there are exceptional opportunities for the hospital to broaden its service offerings. Until reimbursement questions are resolved, diversification into aftercare is likely to be a risky proposition. But aftercare does represent an opportunity for creative extension of the hospital's service mission to a population of elderly that will wield increasing economic and political power in the future, and whose needs are being inadequately met by the existing fragmented system.

One of the most interesting areas of potential diversification is the area of day hospitalization (or day care) for the geriatric patient. For the disabled or otherwise impaired elderly who are nonetheless ambulatory, day hospitalization can provide the mixture of health care, social service, and nutritional monitoring and assistance which many elderly receive in nursing homes. Such programs may fill the gap for that large segment of the nursing home population which does not require continuous nursing care. While the cost of adult day care is slightly higher on a per them basis than nursing home care, preliminary study results suggest that it is from 37 to 60 percent less expensive to the payer, and between 12 and 35 percent less costly to the patient (when nonprogram expenses of independent living are added in), because it is intermittent rather than continuous care. [45]

The establishment of geriatric day care programs in hospitals permits the hospital to build from an institutional base which includes nursing and social services departments and to reprogram potentially under-utilized space to meet new needs. Hospitals with transportation systems can use them to transport patients to and from the hospital, expanding access to the program for those elderly who cannot drive and who live alone. Patients discharged from the hospital can be enrolled in the program.

The geriatric day care model can also be adapted to a community-based setting where the patients are drawn from the community at large rather than from the population of discharged patients. Many community health centers or primary care centers have the capability of adding geriatric day care programs to their mix of services, again without substantial alterations in staffing or mission.

As discussed above, many hospitals offer their own home health care services, which may range from traditional visiting nurse programs to such social services as homemakers and meals on wheels. The liberalization of Medicare home health benefits provides an economic opportunity for hospitals to expand these service offerings. Captive hospital-based home health care programs are cost reimbursed like most other hospital services, requiring a minimal alteration of billing and record-keeping procedures.

While research findings regarding the discovery effect of monitoring of patient conditions through home care may trouble insurers, they point to a marketing opportunity for hospitals to identify unmet health care needs. Not all of these needs can or should be met through hospitalizing the patient. But legitimate medical problems discovered through captive home health care programs can be treated somewhere within the orbit of the hospital's programs, either on an ambulatory or inpatient basis. Hospitals should be able to offer a full enough range of services to the elderly so that home health workers, in cooperation with the patient's physician, can select the

most appropriate and, hopefully, least expensive means of solving medical problems identified through home care.

Even for hospitals which lack the capability or interest in developing captive aftercare programs, possibilities exist for making the hospital the broker between the patient and the bewildering array of alternative services for aftercare. This brokering role is being played already, but without the linkage for fiscal accountability which was established as critical in the Triage demonstration project. The University of Chicago Medical Center, through its social services department, is participating in an experiment which permits the hospital to serve as a clearing house for homemaker and chore /housekeeping services for a consortium of hospitals on the south side of Chicago. This model places on the referring hospital social worker responsibility for assessment of the hospitalized patient and the development of the in-home care services plan. It is responsible for selection and monitoring of home health providers, and for submitting claims to the reimbursing agency. This brokering function will help protect the patient as well as reduce medically unnecessary prolonged patient stays or re-admission, and will help divert as many patients as practical from the nursing home. Thus even where hospitals may not elect to develop their own aftercare programs, they can work with reimbursing agencies to coordinate the provision of aftercare services for their patients.

Through diversification into ambulatory and in-home care for the elderly hospitals can take advantage of their resource and administrative bases to help fill some of the vacuum of fragmentation and lack of accountability discussed above. The linkage to the patient's physician is preserved through such arrangements, and creative means of extending the physician responsibility for chronic care for the elderly through the hospital's nursing and social services staff will help preserve physician accountability for care, a critically missing link in much of the aftercare market.

NOTES

1. Anne Somers, "Rethinking Health Policy for the Elderly: A Six Point Program," Inquiry, Spring *1980, p. 12.*

2. Charles Fisher, "Differences by Age Groups in Health Care Spending," Health Care Financing Review, Spring *1980, p. 60,*

3. Ibid., p. *68.*

4. Ibid., p. *81.*

5. Somers, "Rethinking Health Policy for the Elderly," p. 3.

6. Ibid.

7. William 1. Scanlon, "A Theory of the Nursing Home Market," Inquiry, Spring *1980, p. 25.*

8. American Hospital Association, Hospital Statistics (Chicago: American Hospital Association, *1980), p. 6.*

9. Burton Dunlop, The Growth of Nursing Home Care (Lexington, Mass.: Lexington Books, *1979), p. 29.*

10. William Pollak, "Utilization of Alternative Care Settings by the Elderly," in Community Planning for an Aging Society, Designing Services and Facilities, M. Powell Lawton, Robert J. Newcomer, and Thomas 0. Byerts, eds. (Stroudburg Pa.: Downden, Hutchinson and Ross, Incorporated, *1976), p. 114.*

11. Ibid., p. *116.*

12. Dunlop, Growth of Nursing Home Care, p. *40.*

13. American Hospital Association, Hospital Statistics, pp. *5-6.*

14. Dunlop, Growth of Nursing *Home Care,* p. *47.*

15. House Select Committee on Aging Hearings, *1980,* "Cutbacks in the Medicare Nursing Homes Programs," p. *3.*

16. Dunlop, Growth of Nursing Home Care, p. *76.*

17. Ibid., p. *67.*

18. Ibid., p. *78.*

19. Ibid., p. *7.*

20. William J. Scanlon, "A Theory of the Nursing Home Market," Inquiry, Spring *1980, p. 34.*

21. Bruce Vladeck, Unloving Care (New York: Basic Books, *1980).*

22. Joan Dietz, "Useless Hospitalizations Cited in Reports of Nursing Home Beds," Boston Globe, May *3,1979.*

23. General Accounting Office Report to the Congress, "Entering a Nursing Home Costly Implications for Medicaid and the Elderly," November *26, 1979, pp. 26* ff.

24. Josephine Lee and Mary Stein, "Eliminating Duplication in Home Health Care for the Elderly: The Guale Project," Health and Social *Work, 1980. p. 29.*

25. William Weissert, "Costs of Adult Day Care: A Comparison to Nursing Homes," Inquiry, March *1978. p. 10.*

26. United States Department of Health and Human Services Public Health Service Office of Health Research, Statistics and Technology National Center for Health Statistics, "The National Nursing Home Survey: *1977* Summary for the United States," series *13,* no. *43.*

27. United States Department of Health and Human Services, Public Health Services, Office of Health Research, Statistics and Technology, "Health

United States 1979," December 1980, DHHS Publication no. (PHS) 811232, p. 196.

28. Vince DiPaolo, "Tight Money, Higher Interest Rates Slow Nursing Home Growth," *Modern Healthcare,* June 1980, p. 76.

29. Michael Koetting, *Nursing Home Organization and Efficiency,* (Lexington, Mass.: Lexington Books, 1980), p. 100.

30. Ibid., p. 99.

31. Ibid.

32. DiPaolo, "Tight Money, Higher Interest Rates Slow Nursing Home Growth," p. 84.

33. Ibid., p. 76.

34. Arthur Young and Company, "Home Health: An Industry Composite," New York: Arthur Young and Company, August 1980), p. 2.

35. John Hammond, "Home Health Care Cost Effectiveness: An Overview of the Literature," Public *Health Reports,* 94, no. 41 (July-August 1979): 311.

36. Avedis Donabedian, *Benefits in Medical Care Administration* (Cambridge, Mass.: Harvard University Press, 1976), p. 79.

37. Arthur Young and Company, "Home Health: An Industry Composite."

38. Thomas Wan, William Weissert, and Barbara Livieratos, "Geriatric Day Care and Homemaker Services: An Experimental Study," *Journal of Gerontology* 35, no. 2 (1980): 273.

39. Florence Wald, Zelda Forster, and Henry Wald, "The Hospice Movement as a Health Care Reform," *Nursing Outlook,* March 1980, pp. 173-74.

40. "Survival of Hospices Depends on Insurers," *Modem Healthcare.* November 1980, p. 58.

41. Ibid.

42. Ibid.

43. "Long-Term Care for the 1980's: Channeling Demonstrations and Other Initiatives," hearing before the Subcommittee on Health and Long-term Care, Washington, D.C., February 27, 1980, p. 19.

44. See Figure 3-3.

45. William Weissert, "Costs of Adult Day Care: A Comparison to Nursing Homes," *Inquiry,* March 1978, p. 17.