

Long-Term Care of the Elderly

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LONG-TERM CARE refers to the medical and support services needed to attain an optimal level of physical, social, and psychological functioning by persons who are frail and dependent due to chronic physical or mental impairments. It includes services to prevent avoidable deterioration of health, to treat acute exacerbations of chronic illness, to maintain the greatest possible independence, and to restore the person to the optimal level of functioning that can be sustained. Long-term care is often mistakenly seen as only nursing home care or home health care. It, nevertheless, includes diagnostic, preventive, therapeutic, rehabilitative, supportive, and maintenance services in both institutional and noninstitutional settings. Persons of all ages may require long-term care, not just the elderly. Still, the population aged 65 years and over is projected to increase by 26% between 1980 and 1999, and the population aged 85 and over—the age group most likely to require long-term care—is expected to increase by more than 50% (1). Clearly, there will be greater numbers of older sick patients in the future, leading inevitably to further increases in the cost of long-term care for the elderly.

The American College of Physicians—a national voluntary organization composed of more than 60 000 doctors of internal medicine—is committed to ensuring high-quality health care services for the elderly. At the College's 1980 Annual Session, attention was focused on aging and health care through a series of panels, state-of-the-art lectures, and other thematic devices. This meeting was followed by a College-sponsored conference, entitled "The Changing Needs of Nursing Home Care" (2). The policy enunciated below marks the continuation of sustained efforts by the College to identify ways of improving long-term care services for the elderly.

Summary of Positions

1. There should be created a comprehensive, coordinated, and continuous system of long-term care for the elderly. To achieve such a system, basic changes in our present system are necessary.

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2. Reimbursement policies should enhance the development of a more effective and efficient long-term care delivery system by encouraging integration of acute and chronic care services.

3. Attempts to reduce the cost of health care should not create new financial barriers that impede access to needed long-term care.

4. Internists, by their training and experience, are among the best qualified professionals to determine, provide, and coordinate needed long-term care services for the elderly.

Position 1

There should be created a comprehensive, coordinated, and continuous system of long-term care for the elderly. To achieve such a system, basic changes in our present system are necessary.

RATIONALE

At present, there is not a comprehensive system of long-term care for the elderly in the United States. Services are provided through a multitude of programs and agencies, with each often acting independently of the others, with no centralized responsibility or coordination. A confusing, fragmented, and expensive system exists that contains both gaps and duplication of services. Consequently, many elderly do not receive the services they need, while others receive services inappropriately (3).

Approximately 25 million people in the United States are aged 65 and over, about 11% of the total population (4). Less than 6 million of these people require long-term care assistance (5). Over 1.3 million people are in nursing homes, and 85% of these are elderly (5). As the elderly population expands, increased demands for long-term care are anticipated, particularly for nursing home care.

Within the growing elderly population, the fastest rate of population growth through the year 2000 is expected for the age group 85 years and older. By the year 1999, 1.4 million more people will be in this category than there were in 1980 (1).

The total population of elderly in need of long-term care is expected to increase to between 7.5 and 9 million by 1990. If current patterns of care continue, approximately one third will require nursing home care; one third will be able to remain living in the community but will require some institutional services due to disability or limited resources; and the remaining one third will remain in the community with sufficient resources to make institutionalization unlikely (5). This projection in-

dictates that the nursing home population in 1990 will be double that of 1980.

Substantial changes in the presently existing system of long-term care are needed if the chronic care needs of our elderly population are to be met effectively. The College believes that it is essential to initiate actions now to develop a long-term care system that matches services to individual needs and that minimizes inappropriate placements in institutional settings. Such a system requires effective means to determine individual functional abilities and needs; availability of a wide range of supportive services, including a variety of noninstitutional alternatives; and mechanisms for coordinating the provision and delivery of services.

Despite the statistical projections already quoted, the overwhelming majority of the elderly are healthy; of those requiring long-term care, many need only assistance in personal care or mobility (1). Current financial and systemic barriers are counterproductive; many persons in need of long-term care are placed in settings that foster dependency, when they might obtain equally satisfactory or better care in less restrictive—and less expensive—settings. Most elderly nursing home residents need assistance only with one or more of the daily functional activities of bathing, eating, dressing, or toileting. Relatively few require medical, nursing, or therapeutic services in an institutional setting.

However, under the current fragmented system of long-term care, the nursing home is, for many, the only available source of personal care services. A substantial segment of the nursing home population consists of persons without families able or willing to provide such services and persons covered by Medicaid who are without the financial resources to otherwise purchase such services. Estimates of overall inappropriate long-term care placements range from 10% to 40% (1).

A full array of services should be available through an integrated long-term care system that enables the family (or surrogates) to meet the changing, but continuing, needs of the elderly in the least restrictive settings possible. These supportive services should include in-home assistance, such as provision of hot meals, visiting nurse services, and homemaker services; community services, such as senior citizen centers, community meals, and geriatric day rehabilitation hospitals; and institutional services, including a variety of housing arrangements, intermediate care facilities, skilled nursing home facilities, acute care hospitals, and mental health facilities. Such a continuum of care would better ensure that the elderly obtain appropriate services.

A means of evaluating and referring patients is essential for the efficient use of a comprehensive long-term care system. Periodic diagnostic assessments of functional abilities are needed to determine accurately patient care needs. At the ACP-sponsored conference, "The Changing Needs of Nursing Home Care," a geriatric health care system was proposed that would fulfill this function through a diagnostic assessment clinic (2). In the model discussed at the conference, a clinic based in a nursing home served as the core of a comprehensive sys-

tem. Functional abilities were first assessed, treatments determined, and patients then referred to the most effective setting to obtain care. The model envisioned an integration of the nursing home with other long-term care, ambulatory care, and diagnostic health care centers. The diagnostic evaluation center, regardless of its location, can provide the needed coordination for cost-effective use of the long-term care system.

Primary responsibility for the care of the dependent elderly must remain with family members. Community resources, supported financially by state and federal funding, should supplement family efforts and provide surrogate assistance for those without family resources. Health care provided at home, in a familiar noninstitutional environment, can be a powerful force for preserving and improving the health of the elderly. The General Accounting Office recently reviewed 12 research studies and concluded that clients receiving home health care live longer and are more satisfied with their lives than those not receiving such care (6). The report further recognized that while expanding home health care services may not reduce aggregate national health care costs, other factors, such as differences in services, quality of life, patient and family satisfaction, and health outcomes, also are important.

Consideration should be given to the role of care givers who feel a moral obligation but have no legal requirement to care for the elderly. Presently 60% to 85% of nonprofessional long-term care services received by the disabled elderly are provided by relatives and friends (6), services that otherwise would be prohibitively expensive. The physical and emotional needs of nonprofessionals who provide day-to-day care for their loved ones should be acknowledged. Constant attention to the needs of the functionally dependent can be exhausting and merits some relief. Voluntary care givers should have opportunities to make arrangements occasionally for substitute caring services. Such respite care should be provided through the formal long-term care system; it would permit family members to continue to conduct their own personal lives and maintain their own health, while enhancing their ability to care for their dependent elderly.

Finally, nursing services, in-home assistance, and supplemental community-based services should be extended to the dependent elderly who lack sufficient family resources.

Position 2

Reimbursement policies should enhance the development of a more effective and efficient long-term care delivery system by encouraging integration of acute and chronic care services.

RATIONALE

Reimbursement procedures, both public and private, tacitly recognize the existence of two separate systems of health care: one for acute care and another for long-term care. Such a division is unrealistic and results often in inadequate responses to the medical needs of the elderly. Reimbursement mechanisms generally favor hospital in-

patient acute care, which is more easily quantifiable, because it consists of discrete, measurable services provided over a defined period.

Long-term care, however, is less readily quantifiable. Patients usually do not recover fully from chronic disabilities; proper treatment requires a variety of support services, including domiciliary care and personal care not traditionally considered as part of health care. Nevertheless, the Medicare program prohibits payment for custodial care, defined in *Your Medicare Handbook* (7) as care that is: "primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training; for example, help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine." Yet, this often is exactly the type of rehabilitative care that is needed for someone recovering from a stroke or suffering a chronic disease.

Institutionalized long-term care is covered by Medicaid, but only under limited circumstances by private insurers. Private insurance paid only 0.7% of nursing home expenditures in 1980 and an even smaller percentage of home care (8). In dramatic contrast, over 90% of all public expenditures for long-term care go for institutional care.

Reimbursement policies can play an important role in achieving a more desirable long-term care system. Financial incentives need to be developed to foster innovation in the delivery of long-term care services while assuring that quality is maintained. Sufficient latitude should be permitted to facilitate access by the elderly to that level of long-term care services required for their individual needs without fostering dependency or using resources unnecessarily. Inappropriate institutional placements should be discouraged. Reimbursement policies should encourage early health care intervention for the sick elderly before they become more seriously ill and should be flexible enough to assure continued levels of support that correspond to changing levels of functional need.

Expanded financial access to noninstitutional alternatives would permit greater individual choice, increase physician options regarding treatment settings, and possibly improve patient compliance with prescribed treatment plans. Preventive health care, custodial care, homemaker services, and other alternatives to institutionalized care should therefore be reimbursable by Medicare, Medicaid, and other third-party insurance programs.

The reimbursement system should foster, not impede, networking among hospitals and nursing homes. With such arrangements patients could be transferred more easily among facilities as their needs change. Present reimbursement policies that provide for payment of skilled nursing home care only if it immediately follows discharge from an acute care hospital need to be reconsidered. Such policies encourage unnecessary hospitalizations and impede dependent elderly from obtaining appropriate care. With earlier access to preventive health care, emphasis on home care, and greater coordination between acute and chronic care facilities, overall system costs should be less than if these measures were not taken.

Position 3

Attempts to reduce the cost of health care should not create new financial barriers that impede access to needed long-term care.

RATIONALE

Costs of health care have continued to rise beyond the rate of inflation, and there continues to be a need for greater cost-effectiveness in the delivery of all health care. Although the elderly compose 11% of the U.S. population, they account for 29% of national health care expenditures and 50.5% of federal health care (nonmilitary) expenditures (1).

Medicare pays for approximately 44% of the total health care costs of the elderly; Medicaid, about 13%; and other public programs, about 6%. Thus, 63% of the total cost of health care for the elderly is paid from public funds. The elderly pay approximately 29% of their health care costs out of pocket, and the remaining 8% of total costs is paid by other private sources (9). Much thought and effort are being devoted to reducing the costs of health care and particularly the costs of the Medicare program, which alone accounts for 62% of the federal health budget.

A substantial, although uncertain, portion of reported aggregate health care expenses includes costly activities that in the past were not considered to be health care. These activities include the costs of residential, custodial, and personal care. Although these are legitimate costs of long-term care, they should be differentiated from medical and health care costs. For example, national health care statistics include all expenditures for skilled nursing facilities. Yet, the cost of labor and equipment to provide health care in a skilled nursing facility may be only a small portion of the total cost. Medical care constitutes an even smaller percentage of the total. Much of the cost is for housing, housekeeping services, food, and personal care.

Nevertheless, the costs of health care—and all long-term care—will continue to rise due to the aging of the population. Continuing advances in medical science and technology will increase our ability to care for the sick and frail elderly but can be expected to further increase health care costs. For the near future, increasing amounts of national resources will inevitably be devoted to providing health care for the elderly.

Without question, with the enactment of the Medicare and Medicaid programs in the mid-1960s, access to health care services for the elderly and the poor improved greatly. However, because of budgetary pressures, some proposals being considered by Congress could impose new financial barriers to health care for the nation's poor and elderly. Such proposals include raising copayment and deductible amounts under Medicare, establishing copayment requirements for the categorically needy under Medicaid, raising state income eligibility requirements for Medicaid, and discontinuing state Medicaid coverage for certain "optional" services (for example, certain pre-

ventive and diagnostic outpatient services, eyeglasses, hearing aids, podiatric care, and private duty nursing).

Before such measures are implemented, their impact on public health care should be assessed carefully. Co-payment and deductible provisions create financial burdens that could deter some poor and elderly citizens from seeking needed care. These proposals could also force delays in obtaining treatment, ultimately increasing morbidity and overall health care costs. Thus, they may be self-defeating. Cost consciousness in the delivery and use of all long-term care services is desirable and necessary, but human costs should not be discounted.

Position 4

Internists, by their training and experience, are among the best qualified professionals to determine, provide, and coordinate needed long-term care services for the elderly.

RATIONALE

At present, most medical care for geriatric patients is provided by internists, family physicians, and general practitioners. On average, 28% of the outpatient practice of general internists consists of care for patients aged 65 and over. For subspecialty internists the percentage is 29%, while for family physicians the figure is 11% (10).

The internist increasingly should play a key role in providing long-term health care. Internists are trained to be personal physicians who combine a broad and deep knowledge of the scientific and humanistic elements of medicine and health care with the ability to establish close ongoing relationships with individual patients. Internists characteristically possess the capacity to deal with both the everyday medical needs as well as the complex problems of elderly patients. All internists are trained in the recognized subspecialty areas of internal medicine and increasingly in the formal basic aspects of geriatrics. Certification in internal medicine reflects expertise in geriatric medicine.

The internist, family physician, and general practitioner should continue to be the principal providers of medical care for the elderly (11). Long-term care, however, often requires a range of services that extend beyond the usual scope of traditional medical and nursing care. Personal care is usually required for activities of daily living (eating, dressing, bathing, toileting). Other required services include housing, social and recreational activities, physical therapy, and mental health care. Dental, vision, hearing, and podiatric services are also necessary.

To provide these services most effectively, a team involving professionals in multiple fields may be needed. Such a team generally should include a physician, nurse, social worker, and the family. Dentists, podiatrists, mental health workers, and others should be involved as needed.

The team approach requires leadership, but not autocratic direction. Most daily caring for the frail elderly is provided by nonphysicians, and it makes sense for all team participants to apply their professional expertise without undue burdensome requirements for physician approval. Such relationships within a team afford the

greatest opportunities for the expeditious provision of effective and efficient care. The internist, by virtue of education and experience, is often the professional best qualified to lead and coordinate the long-term care team.

As the number of frail elderly increases and the nursing home population doubles within the next 25 years, the need for coordinated, comprehensive care will increase further. Consequently, there will be an increasing need for physicians who are sensitive to the special problems of the elderly, who can perform diagnostic functional assessments, and who possess the managerial skills as well as clinical knowledge to mobilize health care and social resources.

Although medical education programs in the past have not sufficiently emphasized such training, increased attention to this need is now being given by the profession. The College, through its regional meetings, Annual Session, and other courses in continuing medical education, is a major contributor to geriatric medical education and encourages all internists to become further involved in this educational process.

Conclusion

While this statement delineates major problems in the delivery of long-term care for the elderly and presents policy positions for addressing them, the American College of Physicians recognizes that specific steps, undertaken on a national scale, will be necessary to achieve the changes recommended. The problems outlined here represent the current state of our national predicament and remedies are sought. Surely, these problems, with the passage of time, will become worse. Consequently, issuance of this statement is another step in what will be a continuing effort by the College to work with other organizations and agencies dedicated to improving long-term care services for elderly persons.

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