them, it can also be argued that it is more compatible with a broad commitment to the value of public policies that strengthen the family and support its capacity to care for impaired relatives.

Over 40 states now have some version of consumer-directed care, including 12 states with new cash and counseling programs. But the percentage of publicly supported LTC recipients in CDC programs is still very small (probably less than 5 percent). Consumer-directed LTC programs have the potential not only to improve the quality of care and life of LTC consumers, but also to help address the emerging shortage of LTC workers which could become severe with the aging of the baby boomers (Polivka and Salmon, 2003). The labor shortage issue is discussed at length later in this section of the paper.

b) Community-residential care

Community-residential care includes a wide range of congregate living arrangements and service packages, from small family care homes (1 to 4 residents) to large assisted living facilities (50 plus residents), and many variations on these arrangements in between. The research on assisted living has grown along with the industry over the last ten years with the most extensive and significant findings becoming available since 2000. Although there are still major gaps in our knowledge of assisted living and important questions that remain largely unanswered, we now have a good deal of information that can help us think constructively about the future of the assisted living industry.

Among the most important early sources of information are the three research reports produced by Catherine Hawes, Charles Phillips and their colleagues since 1999. These reports were the first to provide a relatively comprehensive, empirically oriented view of assisted living, which addresses many issues that are integrally related to regulatory policy.

Hawes, Rose and Phillips (1999) conducted their research on a national sample of high-privacy (single-resident rooms) or high-service (above average health and social services) facilities or facilities that are characterized by both, which they estimated to be about 40 percent (4,300) of all ALFs across the country housing about 190,000 residents in the mid-1990s. Their sample consists of 1,500 residents drawn from 300 facilities.

Their second report, High Service or High Privacy Assisted Living Facilities, Their Residents and Staff: Results from a National Survey, Hawes and Phillips (2000), contains several findings which are especially relevant to regulatory and other policy issues in assisted living. During a 12-month period, 19 percent of the residents in the sample facilities were discharged. Only 8 percent were discharged to nursing homes and almost 4 percent to other ALFs. Overall, 60 percent of those who moved did so in order to receive a higher level of care. Only 12 percent of those who moved indicated, through proxy respondents (family members), dissatisfaction with the care they had received in the facility they left. A decline in cognitive status was the only resident variable that significantly increased the likelihood of entering a nursing home. The authors also found that:

Residents in facilities with a fulltime RN involved in direct care were half as likely to move to a nursing home. When different formulations of staffing/service variables were used (any RN staffing, RN hours per resident, aide staffing, arranging for nursing care),
the relationship between services and outcomes was not significant. It appears that these alternative staffing arrangements, or just better staffed facilities, are no substitute for a fulltime RN who does direct care.

In their third report, *A National Study of Assisted Living for the Frail Elderly: Final Summary Report*, Hawes and Phillips (2000) found that resident and staff assessments of their facilities were generally positive with a majority of residents reporting that they were treated with affection (60 percent) and dignity (80 percent). They also, however, reported that 26 percent indicated they needed more help with toileting activities and 90 percent of the residents thought they could stay in their facility as long as they wanted to remain, although most were uninformed about policies governing retention and discharge from their facility.

Kane, Olsen Baker, Salmon and Veazie (1998) found that ALFs and nursing homes in Oregon achieve comparable outcomes in terms of activities of daily living (ADL) trajectories, pain and discomfort levels and psychological well being, after controlling for differences in baseline conditions. Although nursing home residents were substantially more impaired than those in ALFs, these findings are encouraging in terms of the capacity of ALFs to accommodate “aging in place” by providing necessary health care services (Frytak, Kane, Finch et al., 2001). It should be recognized that Oregon has a relatively mature assisted living industry, regulatory policies and public funding strategies designed to maximize the nursing home diversion potential of ALFs and the opportunity for assisted living residents to exercise choice, including the decision to “age in place.”

Another study of community-based programs in Florida found that residence in an ALF reduced nursing home utilization by 47 percent compared to the other in-home services programs (Andel, Hyer and Slack, 2005).

A study by Hedrick, Sales et al. (2003) on assisted living, adult foster care, and adult residential care in Washington state found that persons at every impairment level, including the highest (limitations in all six ADLs), were residing in assisted living facilities, although the adult foster care homes tended to have a higher percentage of more impaired residents and lower payment rates. The study also found very high levels of resident satisfaction in the assisted living and adult foster care programs, with 92 percent of the residents reporting that moving to the setting was a good decision. The residents also reported “very high levels of satisfaction with each aspect of care (p. 480).”

Payment rates ($50-70 per day) in Washington’s assisted living program are higher than the rate for adult foster care ($40 per day in 1998), mostly because of state regulations requiring them to provide private rooms (single occupancy) and kitchenettes, which allow for greater resident autonomy and privacy. Hedrick, Sales et al. (2003) note that:

... AL residents were significantly more satisfied with respectful treatment from staff and with their apartment or room, possibly indicating the influence of the stated AL philosophy of autonomy and privacy, and the required physical layout of separate apartments with lockable doors, kitchenettes, and the like (p. 481).

In a more recent study, (Hedrick, Guihan et al., 2007) of the Veterans Administration Assisted Living Pilot Program (ALPP) found that adult family homes (foster care) enrolled residents needing more assistance with ADLs than the larger assisted living and residential care
facilities which tend to employ more staff with professional health training. The authors speculate that this difference is:

... influenced by some combination of differences in size and layout of the facility, ability to observe residents for potential problems, availability of trained staff for personal care rather than administration and health promotion, level of financial sophistication of the owner/managers, number and economic implications of unfilled beds, and finally goals and cultural traditions of the adult family home providers. (p. 375)

The authors also describe several potential benefits for residents of small facilities including:

... living in a more home-like environment in a family atmosphere with potentially greater individual attention to personal care needs and care preferences such as food choices; the potentially lower costs are a benefit to the system and may allow for greater expansion of the programs. (Hedrick, Guihan et al., 2007 p. 375)

These are important “facts on the ground” that have major implications for the future of assisted living regulation and its role in the LTC system. These studies are based on relatively small samples and much more research is needed. We can speculate, however, about the significance of these findings for LTC policy generally, and regulation more specifically. For example, to the extent that personal control and autonomy are important determinants of quality of life in LTC, assisted living may be the optimal setting of care, including many now receiving care in their own homes. Optimal in the sense that assisted living may be for many frail elderly persons the best setting for achieving an effective balance between control/autonomy and supportive services including health care, and more human interaction to combat loneliness.

For many frail elderly persons with thin or non-existent caregiver networks, assisted living may also be the best setting in which to achieve personal control and autonomy. In a study of quality of life in nursing homes, assisted living facilities (ALFs) and in-home long-term care programs in Florida, Salmon (2001) found that the major predictor of quality of life was the degree of personal control the respondent experienced. Those in ALFs expressed the greatest satisfaction with their quality of life and the level of personal control they experienced. The respondents in the home care programs expressed a clear preference for home care over nursing homes, but they also reported less satisfaction with both their quality of life and personal control than the assisted living respondents.

ALFs can offer the kinds of resources, especially staff services, transportation, and social activities, necessary to make the achievement of control/autonomy a far more practical matter than may be possible in many in-home environments, where achieving the same level of opportunity to exercise personal control is beyond the financial means of most individuals or the public sector to provide, or too great a burden on the individual’s informal care providers. These possibilities should be kept firmly in mind as we think about assisted living regulation and how to achieve the full potential of assisted living as a LTC program.

Indirect, but compelling evidence supporting this perspective is provided in the third Hawes and Phillips (2000) report. The vast majority (85 percent) of their respondents reported that their top two priorities on entering the ALF were the availability of a private bath (#1) and private bedroom. Among those who had left an ALF (19 percent over 12 months) most (65 percent)
continued to identify these same privacy-oriented priorities. The other 35 percent of those discharged identified the presence of an RN or staff and the quality of the staff as their top two priorities. The importance of these privacy provisions indicates that many residents value the opportunities for privacy in assisted living very highly ((Kane et al, 1998). It should also be noted that privacy is often a necessary, if not always sufficient, condition for the effective exercise of personal control/autonomy and for maintaining interpersonal relations (Polivka and Salmon, 2003).

Privacy may be especially important for the quality of life for cognitively impaired residents. Zeisel, Silverstein, Hyde et al. (2003) conclude their study of 427 residents in 15 Alzheimer’s special care units, ranging in size from 20 to 50 residents, by recommending that:

... SCUs [special care units] should strive to model their interior environments after homelike settings to reduce aggressive and other symptoms. Applied in design of SCUs, these findings will lead to more private and less shared rooms, variation in common room design within an SCU, common rooms for activities located at ends of hallways, and doors located along side walls whenever possible instead of at the end of hallways where they act as “attractive nuisances.” (p. 709)

Sheryl Zimmerman and her colleagues (2001; 2005) have conducted extensive survey research in assisted living facilities and nursing homes in New Jersey, North Carolina, Florida and Maryland. They broke their assisted living sample into small (under 16 residents), traditional (16 and over residents) and new model facilities (purpose built and with 16 residents), and surveyed a total of 233 facilities in the four states. Among some of the more interesting, policy relevant findings, they found that:

... with the exception of a discharge policy related to the inability to walk, it makes no difference whether residents are in small, traditional, or new-model facilities in terms of whether the facility is likely to discharge them based on resident characteristics. Factors that do seem to make a considerable difference are the state in which the facility is located, who owns the facility, and the age of the facility. (p. 234)

For example:

Compared with facilities located in North Carolina, facilities in Florida are more likely to have a discharge policy for residents who are unable to get out of bed, who are unable to feed themselves, or who are unable to care for their appearance. ... For-profit status is also associated with a greater tendency to discharge for ADL-related reasons, particularly an inability to bathe, dress, or maintain continence. Finally, as the age of the facility increases, so does the propensity to discharge residents who are unable to walk, eat independently, or maintain urinary or fecal continence. (p. 234)

The new model facilities score higher on policy choice, privacy and policy clarity than the other facility types. The traditional and new-model types both provide more health and social services than the small facilities.

In the second study, Zimmerman and her colleagues (2005) also found that facilities that have more restrictive admission policies, are affiliated with another higher level of care program, or
have registered or licensed practical nurses (RNs or LPNs) on staff are more likely to transfer residents to nursing homes. On the other hand, residents were less often hospitalized when facilities provided more RN care. They also found that small facilities (average 8.9 beds) fared as well as “new model” properties in terms of medical outcomes and nursing home transfers, and better in terms of functional and social decline and social withdrawal (Zimmerman et al., 2005). Other studies have found that small or mid-size properties are often less expensive and more willing to accept Medicaid and SSI-supported residents than are larger properties (Salmon, 2003; Stearns, 2001), a finding that has major implications for state LTC policy and the use of Medicaid-waiver funds to expand community-based alternatives to nursing homes.

These findings indicate that the larger and newer facilities are better able to provide services and meet the privacy and autonomy desires of residents. Small facilities, however, may provide more familial, homelike settings that many impaired elderly seem to prefer and are willing to give up some privacy and autonomy in order to live in such facilities. Many may also prefer to age in place in small facilities, even in the absence of some of the health services offered by larger facilities. The major point is that potential residents should have an array of facility types, including small, less-sophisticated facilities, to choose among.

Morgan, Eckert, Gruber-Baldini and Zimmerman (2002) suggest that researchers, policy makers and regulators exercise caution in defining and comparing facilities for purposes of descriptive and evaluative analysis, and for regulating the range of facilities that may be described as assisted living. Small facilities, for example, may not be able to offer the same level of control and autonomy, or service as larger, purpose-built (new paradigm) facilities, but residents, as noted above, may well find them more homelike, more affordable and accommodating enough in terms of autonomy/control, especially in comparison to the nursing home setting or even their own homes. In sum, the advantages and shortcomings of the whole range of assisted living options should be recognized without claiming that one style of assisted living is necessarily superior to another or better designed to meet everyone’s needs, preferences or ability to pay.

Policies, funding, and regulatory strategies should reflect our awareness of and support for the different forms of assisted living and the need to provide the consumers with as many options as possible to choose from, as long as they are consistent with the basic values of the assisted living philosophy and basic safety requirements. This means that small facilities should not be held to precisely the same standards, which they are not likely to meet, as the larger, purpose-built, new paradigm facilities. Zimmerman, Eckert, Morgan et al. (2002) note that if regulation and funding turns on adherence to the new paradigm’s parameters, it may mean the demise of the smaller facilities. This perspective will undoubtedly complicate the way assisted living is regulated, but if it results in maintaining, or supporting the expansion of the range of community-residential options available to consumers of housing with services, then it should be considered worth the additional complexity.

Findings from Morgan, Eckert and Lyon’s (1995) study of small board and care homes in Baltimore and Cleveland also support the view that small facilities have the capacity to serve a wide range of residents, including those with serious impairments. The authors point out, however, that the popularity of small facilities could increase the perception among policy makers that they need to be more rigorously and conventionally regulated, which they think
could eventually lead to their extinction, or at least substantially reduce their affordability and overall appeal.

The importance of small facilities from a quality-of-life perspective is evident in findings from a study by Ball, Perkins (2005) of a range of facilities (large and small) in Georgia. The authors found that the quality of internal social relationships was commonly better for residents in the small, family model facilities, especially for those without routine contact with family members. The importance of internal social relationships is supported by the results of a study by Street, Burge, Quadagno and Barrett (2007) who found that they were the major predictor of the overall quality of life of all residents.

Community-residential care is not for everyone requiring LTC assistance, especially for those who develop extensive and complex medical care needs. For many assisted living residents, however, a substantial amount of “aging in place” is already occurring in ALFs and the number of residents who “age in place” without ever entering a nursing home is likely to increase in the future, as assisted living providers become more confident of their ability to accommodate the changing needs of residents in a relatively flexible regulatory environment. Findings from a study by Ball et al. (2004) demonstrate the complex and often idiosyncratic nature of “aging in place” in assisted living facilities: there may be as many ways of “aging in place” as there are ALF residents and overly precise regulations specifying the terms of retention precisely are likely to end up displacing many residents whose quality of life is largely dependent on remaining in their ALF. Ball et al. conclude that resident pathways to “aging in place” are:

... influenced by multiple factors relating to the wider community outside the home, the physical and social environment of the facility, and the individual resident. The relationship between these factors was complex and dynamic, and the phenomenon of aging in place represented a balancing act that depended on how various factors acted and interacted in the context of each ALF. Central to a resident’s ability to age in place was ultimately the “fit” between the capacity of both the facility and the resident to manage resident decline. (p. 205)

The findings reviewed here indicate that, overall, assisted living is often an optimal environment for residents as they age in place, including many residents with cognitive impairments and medical needs. There is a danger, however, that as a consequence of serving an increasing number of cognitively and physically impaired residents, states will impose restrictive regulations that will unnecessarily limit the potential of assisted living to serve this population (Chapin and Dobbs-Kepper, 2001).

Furthermore, as Ball et al. (2005) pointed out, regulatory policy should recognize the unique value and challenges of small facilities. Regulations should not be allowed to drive small facilities into extinction and should be:

... advocates for the elderly are well intentioned when they push for better physical environments, stricter enforcement, and more accountability, but older persons of limited means are far better served by calibrating the standards to fit the available resources than by hiking expectations beyond the ability of that market to reach them. (p. 264)
The biggest problem in assisted living at this point is not insufficient regulation. The major problem confronting policy makers and those in need of LTC is the relatively meager number of assisted living beds available to the less affluent elderly who require public support, have limited access to community resources, and want to avoid ending up in a nursing home. For many of these people, assisted living offers the optimal LTC setting for not only receiving the physical care they need, but also for achieving a quality of life (autonomy, privacy) that may not be available in their own homes. Our primary goals for assisted living should be to expand access for publicly supported residents and avoid regulatory schemes that would undermine the quality of life features that constitute the fundamental appeal of assisted living as a LTC program.

Medicaid waivers are essential to LTC financing as demonstrated by the way they have been used to transform care for the developmentally disabled over the last 20 years and LTC for the elderly in Oregon, Washington and Arizona over the last decade. These examples indicate the capacity of waivers to change the fundamental nature of LTC on a permanent basis and help address the fiscal crisis by containing overall LTC costs. Very few states, however, have adopted the Oregon and Washington approach to funding the growth of affordable assisted living through the Medicaid program.

Policy makers, assisted living providers and residents will continue to struggle for the foreseeable future with “a number of issues that require reconciliation of what appears to be inherently contradictory goals (O’Keeffe and Wiener, 2004, p. 4). According to O’Keeffe and Wiener, these issues include:

- Meet expectations for privacy, amenities, and quality services that have been set by the private pay dominated model of “assisted living” when Medicaid cannot afford to pay private pay rates.
- Cover the actual costs of serving frail older individuals with chronic care needs in residential care settings, when Medicaid is not permitted to pay for room and board and the payment sources available to cover room and board are insufficient.
- Giving consumers a sense of what they should reasonably be able to expect from a setting that calls itself “assisted living” or “adult foster care” or some other name, without imposing uniform definitions through state regulation.
- Assure a minimally acceptable quality of care without imposing rules that stifle improvements and without the regulated “floor” becoming the “ceiling.”

Assisted living is a relatively fragile form of housing and LTC that is largely sustained by the fact that many older people very much prefer it to nursing home care and may, in many cases.

At this point, I think the available research indicates that most of the state regulatory standards governing “quality of care” (standards setting minimally acceptable quality) and “aging in place” (standards allowing flexibility in terms of facilities deciding whom they will admit and retain) are generally sound, but that disclosure standards need to be more fully developed. The financing issues will remain problematic in terms of both funding levels and reimbursement rates and restrictions (no room and board coverage) until federal and state policy makers decide to make assisted living and adult foster care as available as institutional care in the publicly funded LTC system.

Many find it preferable to in-home care. It would not take the application of very many nursing home style regulations, however, to make assisted living substantially less affordable and far less attractive than it has proven to be over the last ten years.
Assisted living has grown enormously since 1990 (one million assisted living residents in 2007), but the availability of publicly supported assisted living is still very limited in most states. Oregon and Washington have long demonstrated the capacity of assisted living to help contain nursing home use and provide a high quality of LTC assistance to impaired persons who can no longer remain in their own homes. The demographic characteristics (fewer children and spouses) and lifestyle preferences (independence and autonomy) are likely to make assisted living a highly preferred option for the baby boomers, regardless of their individual financial resources (Polivka and Salmon, 2008).

Adult Foster Care is a largely neglected LTC resource in most states, even though Oregon and Washington long ago demonstrated its utility as an essential part of both the public and privately funded LTC system. Oregon now has over 6,000 adult foster beds, 70 percent of which are filled by private-pay residents. An evaluation in Washington found that residents of foster homes and small assisted living facilities were highly satisfied with their care arrangements which were among the least expensive of LTC programs (Hedrick et al., 2003).

The instructive examples of Oregon, Washington and a few other states with relatively balanced LTC systems and the research supporting the relative cost-effectiveness of HCBS programs and the public preferences for them may not be enough to speed up the creation of community-based LTC systems to the extent needed in the face of population aging. The pace needs to be much faster over the next ten years than it has been for the last 20 years. Aging and LTC reform advocates supporting the rapid expansion of HCBS programs should form advocacy coalitions with labor unions, especially those representing caregiving workers like SEIU, and retiree organizations like state retired teachers associations, and other organizations of retired professionals.

c) An ethical framework for long-term care reform

The inherently ethical implications of LTC policy decisions have not yet led to a comprehensive consideration of the ethical aspects of the gap between what we know and what we do in providing LTC services for the frail elderly as occurred in the DD community over 30 years ago. While we need to continue to conduct research studies on LTC options, we should not expect that the results of research alone will create sufficient conditions for a profound change in the direction of LTC policy. Such change will require a collective change of heart that is fundamentally dependent on the creation of a clear moral vision for LTC. Research can help us identify the most efficient and consumer-responsive methods of achieving policy priorities guided by a moral vision. Research is not, however, a substitute for the kind of moral reasoning we need to undertake as a community and as an aging society.

The developmentally disabled (DD) and disabled adult (DA) communities have achieved a far more diversified, consumer-oriented community-based LTC system than we have been able to create over the last 25 years for the frail elderly. Research comparing the relative cost-effectiveness of home- and community-based versus institutional care for the DD and DA populations is not qualitatively more extensive or conclusive than the research results now available on the frail elderly population; yet, the absence of complete certainty did not keep the
DD and DA communities from transforming their LTC systems over the last 25 years by pressing for more humane and autonomy-enhancing LTC programs.

This discrepancy has been attributed to differences in the kinds of physical or cognitive impairments experienced by these populations, differences in the extent of family involvement and commitment, and the level of self-advocacy. These differences are less important than the fact that the aging research and advocacy community does not have a coherent, compelling moral vision and ethical theory comparable to the developmental/normalization model that has guided DD policy and practice since the early 1970s or the commitment over the same period to autonomy and self-direction that has driven the development of policies and programs for younger disabled adults (Cohen, 1988).

The DD community has long benefited from well-organized, intensive advocacy initiatives at the federal and state levels. These initiatives have historically been guided by a moral vision and ethical framework (a theory of rights and obligations) grounded in the normalization principle. From the perspective of the normalization principle, developmentally disabled individuals may be different from others, but these differences are not viewed negatively; society must be prepared to support and nurture them. This represents a major framework for understanding and treating developmental disabilities.

In the case of disabled adults, advocates in the independent living movement have largely recast disability as an oppressed minority group status which has allowed the disabled to advocate for a more responsive and supportive environment and to generate sources of self-empowerment for the disabled adults. By comparing the independent living orientation of non-elderly disabled with the perception of dependency imposed upon the elderly disabled, impairment is, in substantial part, socially constructed:

... we speak of the disabling environment. This concept places the locus of disability not solely within individuals who have impairments but also in the social, economic, and political environment. By this argument, people are impaired but the environment is disabling. (Albrecht 1992)

Contrasting this perspective with the currently dominant view of the disabled elderly:

... whereas access and full participation have become key concepts for the younger disabled population, for disabled elders, the rights of families and professionals, and of the disabled elders themselves, tend to be far more circumscribed. In this way, aging professionals, elders, and society in general appear to have traded earlier, limited views of aging for an even more limited view of what it means to be old and disabled. (Kennedy and Minkler, 1999)

What kind of ethical framework would begin to do the kind of work for the impaired elderly that the developmental model and normalization principle have done for the developmentally disabled for almost 30 years? The following framework is offered as an initial outline for an ethic of LTC that may have the potential to serve as a guide in the development of a LTC system that is more responsive to consumer preferences and that can help us use what we know about what works to change the way we provide LTC.
The conventional concept of personal autonomy that is integral to acute care oriented bioethics, with its heavy emphasis on an individual’s independence, nonintervention, and rational decision-making, does not provide a practical framework for an ethic of long-term care; it is too abstract and removed from the complex realities of LTC. Autonomy is more than just the power of an individual to keep others from intervening in her life without fully informed and uncoerced consent. Autonomy is also the power of an individual to interact and communicate freely with others, to give and receive affection, and to initiate actions that are consistent with her sense of self. This version of autonomy is especially important in developing an ethic for long-term care. Few persons requiring LTC services fit the bio-medical ethics model of the fully competent, independent individual whose goal is achieving freedom from intervention by others (Agich, 1993).

We need a richer, more complex concept of autonomy that brings in the real world of the day-to-day life of LTC recipients and recognizes webs of interdependence. This notion of autonomy can shape policies and service strategies that help preserve a disabled person’s sense of self and extend the boundaries of her own volitional capacities by offering a wide range of home- and community-based services, including CDC.

The development of these programs should not be governed by cost-effectiveness criteria only. There is value in preserving autonomy that should be included in any assessment of LTC costs and outcomes. Just such a perspective guided the development of the first HCBS programs for publicly supported consumers in most states. This vision featured a commitment to quality-of-life values, including autonomy, privacy and dignity, and other values that are more achievable in a person’s own home or, if desired, a homelike residential care setting designed to support resident autonomy and control.

An ethics-based critique of current LTC policies for the frail elderly could become as important a force as cost-effectiveness analyses in changing the direction of policy. Insofar as what is best for the frail elderly, according to their own values and references, becomes a principle criterion for assessing and developing policy in the direction of LTC policy for the frail elderly with change in the same way it has changed for the DD population over the last 20 years.

Section IV. Long-term care labor force issues

The growing need for LTC services is creating a shortage of LTC workers which is likely to reach crisis proportions by 2015. The need for LTC workers of all kinds from registered nurses to assisted living administrators to direct care workers will increase by 50 percent or more by 2015 (Institute of Medicine, 2008). This percentage is likely to be even higher in much of the Appalachian and Southern Regions where the older impaired population is projected to grow faster than in the U.S. as a whole. Most of the U.S. is already confronting a LTC labor shortage as wages, benefits, and working conditions fail to provide the kinds of incentives needed to narrow the growing gap between the demand for and supply of LTC workers (Institute for the Future of Aging Services, 2007). The consumer directed care (CDC) program model described earlier will help address the LTC labor shortage by pulling more family and friends into the formal LTC system, given the declining number of informal caregivers. An expansive CDC program, however, will not by itself resolve the LTC labor crisis due to the growth of smaller
families, higher divorce rates, and childless individuals. A more comprehensive labor force strategy will be required—a strategy that should be a fully integrated part of any proposal for systemic reform of LTC at the state and federal levels (Stone and Dawson, 2008). The urgency of the LTC labor force challenge is noted by Wiener (2006):

The elephant in the room receiving relatively little attention is the issue of workforce. Long term care is a uniquely hands-on, personal service provided by human beings. While we can hope for technological fixes, the personal nature of the service makes that difficult. We need people to provide long term care. Currently, we face workforce shortages, with high turnover resulting in lack of continuity of care and numerous vacancies limiting expansion and improvement of services (Stone and Wiener, 2001). Given the low wages, lack of benefits, and job structure for certified nurse assistants, this is not surprising, but the situation can only get worse as the demographics change. The ratio of persons age 22-64 (the working-age population) to the population age 85 and over (the population in need of long-term care) is projected to decline from 34.6 in 2005 to 11.4 in 2050 (U.S. Bureau of the Census, 2004). This demographic change will have enormous impacts on the ability to provide services, what those services will cost, and the quality of those services. Unless we find ways to entice more people to provide long term care services and find a “we” to improve the quality of that care, we will face problems that will dwarf our current difficulties. (p. 32)

The age 85 plus population has grown by 25 percent over the last ten years and the working-age population of 25-54 has barely grown at all. This demographic discrepancy will grow steadily after 2010 as the age 85 plus population is projected to triple by 2050 and the age 25-54 group will grow much more slowly. The growth in the need for LTC services over the next 40 years will increase the demand for LTC workers from 1.9 million in 2010 to over 4 million in 2050. This will require a 2 percent annual increase in the LTC workforce over a 40-year period. The working age population, however, will grow by only 0.3 percent over this period (Stone, 2001). Addressing this discrepancy effectively will require a multifaceted labor force strategy, including initiatives to ramp-up productivity in the LTC sector, mainly through the more expansive use of technology, improved worker wages, benefits, training, and working conditions designed to make LTC employment qualitatively more attractive and new models of service delivery like consumer-directed care more efficient and cost-effective.

The increasing need for LTC services, the necessary expansion of publicly funded services, and the continuing effort to improve the quality of care and of everyday life for residents and workers may drive LTC costs higher than currently projected over the next 30 years. Would this be a seriously deleterious outcome from an overall economic growth and quality of life perspective? Is there some line that once crossed will damage the economy in some catastrophic manner? Is there a better way to invest our resources than in efforts to improve the quality and availability of efficiently administered health care services, including LTC services? We can already see one of the major economic benefits of relatively high health care spending in the fact that the health care industry is now the most reliable source of job growth, including many good paying jobs, in our economy. We certainly need greater efficiency in the health care economy. We should not, however, lose sight of the tremendous economic advantages of a growing health care sector.
Meeting these labor shortages and even larger ones that will emerge in the future will depend on improving the quality of LTC jobs. The overwhelming likelihood that demand will outstrip supply in the LTC labor force in the U.S. will probably make home health care, personal care, certified nurse aides, and other LTC-related jobs increasingly attractive in terms of wages, benefits, and working conditions.

Current wages of direct care workers like Certified Nursing Assistants (CNAs) average $7.00 to $9.00 dollars an hour and work about 30 hours a week on average, which comes to $16,000 to $20,000 annually, or less than the poverty level for a family of four. Direct care workers actually make more money in whatever jobs, including the fast food industry, they take after leaving nursing home employment. In terms of benefits, less than half of direct care LTC workers have health insurance coverage or pensions, annual sick leave, or vacation days (Hyer, Even and Macpherson, 2008).

The relative paucity of benefits, low wages, and often poor working conditions, including heavy workloads, very little job autonomy, participation in patient care decision-making, or career development based on systematic training and career ladder opportunities, are major reasons for the high annual turnover rates in LTC-related jobs (Stone, 2001). Turnover ranges from 30 to 100 percent annually for CNAs in nursing homes across the country. High turnover rates threaten the quality of care and are expensive—replacing a home care worker costs about $3,400 on average (Hyer et al., 2008).

Research recently completed by economists at Florida State University and the University of Miami for the Florida Policy Exchange Center on Aging (Hyer et al., 2008) found that turnover rates for registered and licensed practical nurses and CNAs in LTC can be significantly reduced by a range of interventions. Higher wages, more benefits (pensions and health insurance), union memberships, and increased training reduce turnover rates for nurses, CNAs and home care workers. For example, CNA turnover can be reduced by 1 percent annually by paying $600 for health insurance benefits. It costs more to reduce turnover by raising wages than offering pensions and insurance, but increasing labor shortages and growing unionization will probably push up wages at a fairly steady rate over the next three decades.

Robert Kuttner (2008) has called for making the improvement of human service jobs, like certified nurse assistants (CNAs), the centerpiece of a new employment policy designed to increase the standard of living of millions of workers who have not, in effect, gotten a raise in 30 years, to improve the standards of child care and elder care qualitatively, and to increase overall economic performance by putting more money into the hands of workers and increasing their purchasing capacity. Human service jobs cannot be shipped offshore and, if properly remunerated, could begin to replace the good manufacturing jobs that have been lost to low-wage economies in the developing world. The Scandinavian countries have no low-wages/no benefits human service jobs because “... it has made a decision that everyone who take care of the sick, the old, or the young is a professional or at least a paraprofessional and is compensated as such” (Kuttner, 2008, p. 148).

Kuttner (2008) suggests that human service jobs in the U.S., 60 percent of which are publicly funded, could be dramatically improved by requiring that:
...any job in the human services supported in whole or in part by federal funds would have to pay a professional wage and be part of a career track. A minimum starting annual salary might be $24,000 a year, or about $12 an hour, which compares with hourly pay levels of $6 or $7 that are now common in nurse-aide, home-care, and child-care work. Opportunities for genuine advancement with pay increases would have to be part of the plan. Rather than using budget pressures to cut these wages, national policy would seek to raise them. (p. 149)

Addressing labor shortages and reducing turnover will inevitably make LTC more expensive. On the other hand, however, employment opportunities for lower income workers will be improved with benefits for the whole economy and the quality of LTC is likely to be enhanced. These initiatives are also likely to improve employment opportunities for work support services like child care, which LTC workers will have more money to purchase—creating a virtuous circle than can help reduce the caregiving deficit that has emerged in the U.S. over the last 30 years and will soon become a caregiving crisis if these steps are not taken.

The discrepancy between the growing need for LTC services and the relatively static population of younger workers is likely to make LTC providers increasingly dependent on older workers, many of whom have lost jobs in the shrinking manufacturing sector and have suffered increasingly longer periods of unemployment over the last several years.

A recent survey of nursing home and home health employees, and several hundred low-income older workers (55 plus) participating in seven operationable programs across the U.S. generated several findings that have implications for initiatives designed to increase the employment of older workers in the LTC industry (Hwalek, Straub and Kosniewski, 2008). The survey found that 43 percent of these workers were interested in direct care work, with 69 percent expressing an interest in working in someone's home, and 57 percent willing to work in a nursing home or other institutional environment. This preference was consistent with the hiring practices of employers in the survey; home health employers reported that 27 percent of their current employees were age 55 or older and nursing home employers reported that 18 percent of their employees were 55 or older. A substantial majority of the employees felt that their health status was sufficient for front-line work in LTC.

Both employer groups reported largely positive views of older direct care workers. Their only reservations were that older workers have higher health care costs and are less willing to use technology. The authors conclude from their findings that low-income older workers are a promising pool of potential direct care LTC workers but that policy changes are needed to tap this potential more fully, including the following:

...policy makers can...target Title V funds toward specialized training of older workers for jobs in long-term care. This study found that most employers in long-term care hire workers who are already certified. Low-income older workers’ comments during the focus groups indicated that some fear they cannot afford the costs of the 75-hr certification training, and some lack confidence in their ability to complete a rigorous training program. Title V specialized training funds can be targeted to increase the pool of direct care workers who are aged 55 and older by paying for the tuition costs of certification training and the development
of certification programs that are tailored to the learning styles of older workers and that will build workers’ confidence in learning new skills.

Policy makers can develop or strengthen policies requiring employees to use mechanical devices and to be adequately trained in the proper use of these devices. A clear message from this study is that age itself is not the main deciding factor in employers’ decisions to hire direct care workers. It is also clear that mechanical devices can be used both in nursing homes and in the community to greatly reduce incidents of workplace injuries and allow older workers with less physical strength to effectively perform frontline work. Employers voiced that although these devices are expensive, the expense may be offset by the reduction in injury-related costs.

Policy makers can investigate how state workforce development funds can support direct care worker initiatives. Results clearly show that very few long-term care employers have accessed any public money to recruit, train, or retain direct care workers. When employers did access public money, most often the funding came from the state. . . . Workforce investment boards, for example, might be one mechanism for obtaining resources to develop a system to screen for the physical capacity of older long-term care job candidates and for giving grants to agencies to cover the cost of certification training. (Hwalek, Straub and Kosniewski, 2008, pp 102-103)

These findings and policy recommendations would appear of special relevance to the 18 national non-profit organizations, including Senior Service America, responsible for administering grants for the Senior Community Service Employment Program (SCSEP). The SCSEP is funded through Title V of the Older Americans Act and had over 92,000 enrolled participants in 2006, 33 percent of whom were in unsubsidized placements. In most states the Office on Aging operates the program at the state level. Participants must be at least age 55 and have a family income of no more than 25 percent above the poverty level. Participants receive a wide range of services including:

Individual Employment Plan (IEP) development, orientation, community service placement, training specific to community service assignment, other training as identified in the IEP, supportive services, wages, fringe benefits, annual physicals, assistance in securing unsubsidized employment, and access to local One-Stop Career Centers. (U.S. Department of Labor Employment & Training Administration, 2007, p. 1)

SCSEP participants are placed in a variety of community service activities in non-profit public facilities, including senior centers and hospitals. In order to position participants for increased employment in the LTC industry, policy changes may be needed, including the targeting of funds toward training for jobs in the home health agencies, nursing homes, assisted living facilities, and as consumer-directed care workers. This kind of policy focus could be especially helpful in the Appalachian and Southern Regions where LTC needs, labor market shortages, and the need for employment among older workers will become increasingly acute over the next several years.

Placing greater value on caregiving work will not only improve the quality of care provided by enhancing the care worker’s sense of dignity, self-respect, and empowerment. Our whole moral culture would benefit enormously from this greater appreciation of caregiving work and recognition of the fact that this work, like teaching, is as important as corporate management,
lawyering, accountancy, or any other kind of work in its contribution to our overall quality of life, and our animating sense of what it means to be a human being. These initiatives should be made part of a comprehensive, family-oriented, economically developed policy designed to provide children with a strong cognitive start, the frail elderly with high quality LTC, and support for mothers to remain in the labor force where they will increasingly be needed in the future to sustain economic growth.

Discussion/Conclusion

The number of people requiring some level of LTC assistance will increase very substantially over the next 30 to 40 years as the age 65 plus population doubles between 2000 and 2040 and the 85 plus population increases fourfold. These increases in the older population are likely to make LTC an increasingly urgent public policy issue and highlight the fact that in most states publicly funded LTC systems are disproportionately dependent on nursing home care.

This absence of balance in the public LTC systems reflects a fundamental gap between what we know (knowledge) and what we do (practice) in LTC. We know that older people and their families greatly prefer home- and community based (HCBS) LTC services over institutional care; and, based on the experiences of at least a half-dozen states over the last 20 years, we know how to provide community-based LTC services in a relatively efficient and cost-effective manner. This knowledge, however, has not been sufficient to change LTC practices qualitatively in most states, which continue to spend three to four times more on nursing home care than on HCBS programs.

Efforts to close the LTC knowledge-practice gap in most states must be informed by an awareness of several sources of resistance or barriers to closing the gap. These barriers include the absence of effective (aggressive and sustained) advocacy for LTC change in most states and at the national level. This absence of tough-minded and sustained advocacy in support of transforming LTC services for older people stands in sharp contrast to the largely successful efforts of advocates for the younger disabled and developmentally disabled populations to shift the focus of LTC for those populations from institutional to community-based care. Other barriers include the largely unfounded fear among policy makers that the HCBS programs will drive up LTC costs because they are so much more appealing than institutional care and the resistance of the nursing home industry to the expansion of community alternatives to nursing home care. Both of these barriers could probably be overcome if the first barrier (absence of advocacy) is addressed effectively.

These and other factors, including fiscal shortfalls over the last 20 years, are probably responsible for the fact that only a few states have achieved a reasonably balanced and cost-effective system of LTC services. This lack of HCBS growth in recent years is problematic in light of the fact that the 2000 to 2015 period is the last window of opportunity the federal government and the states will have to balance their LTC systems before the older population and those needing LTC assistance begin to increase at an accelerating rate.

Drawing on the experience of the relatively few states that have made the most progress in creating more balanced LTC systems, there are several steps the other states could take to
expedite the balancing of their own systems. These steps include the integration of policy and budget authority for all LTC programs (HCBS and nursing home programs) through either administrative consolidation or managed LTC strategies; the explicit commitment of policy makers to substantial annual increases in funding for HCBS programs, especially consumer-directed and community-residential programs and the clear articulation of an ethical framework for LTC change by aging-oriented advocacy organizations.

The aging network has played a critical role in many states over the last three decades in the development and administration of home- and community based long-term care services. This history raises the issue, however, of what the future of the aging network at the state and local levels should be and of what steps should be taken to best position the network at every level for the huge increase in the demand for long-term care services over the next three decades. Brodie and Costora (2008) have raised the possibility of establishing national performance outcome standards for the aging network in order to build on the demonstrated strengths of the networks in many states in managing comprehensive community-based long-term care service systems. This kind of national strategy could expedite the spread of best practices and accelerate the development of more integrated, cost-effective and consumer responsive long-term care systems across the states in advance of the "age wave." This may be a controversial proposal but it is one advocate and policy makers would be well advised to begin debating as soon as possible.

We need to have this debate and develop a consensus strategy relatively soon in order to avoid being swamped by the emerging policy battles over the funding of the entitlement programs and health care reform. Long-term care is still something of a backburner policy issue in Washington and in many states, but it will not remain in obscurity much longer with the growth of the older population, the shaky economy and the latest manifestation of the fiscal crisis of the state at virtually every level. The Older Americans Act funding has actually lost 30 percent of its purchasing power since 1980 and the older population has grown by over 40 percent since then. This is the reason that some local jurisdictions have decided to generate local resources to meet the needs of their low-income older residents who are not eligible for Medicaid services. This, however, is not a viable strategy for meeting long-term care needs in a relatively uniform fashion, given the great variance in financial capacity across communities within and between states. We can also expect increasing pressure to contain or reduce Medicaid expenditures as the fiscal vice tightens in DC and in state capitols. These trends (growing need and struggles over stagnant resources) constitute the critical context for thinking about the future role of the aging network and its capacity at the state and service delivery levels to respond to these imminent challenges.

The aging network varies enormously across the country with budgets ranging from a few hundred thousand to over two hundred million. The number of persons served range from a few hundred to over 125,000 (Kunkel & Lackmeyer, 2008). We know that area agencies and aging network providers vary a great deal in terms of the kinds of services provided, levels of organizational and information system complexity, and along many other dimensions. We have considerable evidence that the states with the most balanced long-term care systems and the most extensive arrays of home- and community-based services have some organizational features in common. These include administrative structures and budgets that are relatively more integrated.
than in states with less developed home- and community-based long-term care systems; a wider range of home-and community-based service options, including consumer direction and community-residential programs; single access points that efficiently manage access to information and services, including expedited eligibility processes; and well-developed information systems designed to monitor consumer services and outcomes on a timely and accurate basis; and systematically provide services to those who want to transition out of nursing homes.

Other factors are also emerging as important in the development of more balanced long-term care systems, but these appear at the moment to be the most relevant for any effort to design a set of national standards that could be used to raise the floor for long-term care programs administered by the aging network. National standards along these lines could be a major resource for state and local aging network leaders who want to use the social and political capital (community confidence) the aging network has been able to generate over the last 30 years to build more comprehensive and better balanced long-term care systems to meet the steady growth in the need for long-term care services. Local variation in aging network operations is to be expected and often supported. It should also be recognized, however, that local variation may not be as important as increasing the aging network’s capacity to serve more people in a wider array of home- and community-based programs in an efficient and effective a fashion as possible by drawing on established “best practices,” some of which may be formulated as national standards.

The aging network at every level represents an extraordinarily successful initiative to improve the quality of life of older persons through public/private partnerships. No other population in need of long-term care and other kinds of assistance benefits from an organizational arrangement comparable to the aging network. This success now makes it possible to talk about the creation of what Brodic and Castora (2008) call “a truly national network” based on national standards that would permit considerable variation at the state and local levels in strategies for achieving them. They note that:

In our increasingly mobile and diverse society, only a national network will be able to accomplish national goals through locally adapted means. In fact, a national network is crucial in giving Americans the confidence in “the system” to provide access to affordable and attractive long term care options even if their family is not at hand to be their advocate. That was the promise of the Older Americans Act, and that is what America can do to make the public and private costs more affordable and sustainable for our aging society. (p. 28)

The Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) have taken several steps over the last ten years to build on the network’s strength and enhance its capacity to serve both Medicaid and non-Medicaid populations. The AoA initiatives include the Caregiver Support Program, the Aging and Disabled Adult Resource Centers, the Evidence-Based Preventive Health Program, and the recently implemented Nursing Home Diversion Program for the non-Medicaid eligible population. The aging networks in many states have been very active participants in the CMS New Freedom Initiative, including the Real System Change, Nursing Home Transition, Money Follows the Person, and other grant programs. The National Area Agency on Aging Association (N4A) and the National Association of State Units on Aging (NASUA) have built on these efforts to develop a collaborative project
(Project 2020) designed to prepare the aging network for the next stage of its evolution. The aging network through its own organizations (N4A and NASUA), and in collaboration with AARP, the National Council on Aging, and other organizations should take decisive steps to formulate a long-term care reform agenda designed to accelerate the expansion of home- and community-based long-term care services. The Project 2020 represents a promising step in this direction.

The cost of long-term care services will become an increasing burden on the states with the huge growth in the age 75 plus population over the next 30 years. Many states are already experiencing severe fiscal stress which will only increase with the emerging economic downturn. The need for state services will increase at the same time that revenues are becoming stagnant or declining. Spending on long-term care services is likely to fall further behind at a time when the states and the federal government should be expanding long-term care services, especially home- and community-based services, in preparation for the unprecedented future growth in the older population. Instead, most states on the other side of the emerging recession, which threatens to be deeper than any since 1981-1982, may face a wider gap between long-term care needs and resources than ever before. They will be poorly prepared to meet the long-term care needs of the aging baby boomers.

The boomers are not likely to be any better prepared than their parents to meet the need for long-term care assistance on their own. The national retirement risk index (NRRI) developed by Munnell, Golub-Sass and Webb (2007) at the Center for Retirement Research indicates that many future retirees will have an increasingly difficult time maintaining an adequate standard of living in retirement and may be even less able than their parents to cover long-term care costs on their own. This trend, in combination with the growing pressure on state budgets caused by increasing Medicaid costs, will make questions regarding the relationship between the role of the public sector and personal responsibility in meeting long-term care needs an increasingly important part of the debate over the relationship between states and the federal government in the funding and delivery of health care services. Support for incorporating long-term care into the Medicare program is likely to grow over the course of this debate—support based on the rationale that a uniform, federally administered long-term care program would be a more efficient and equitable strategy for providing long-term care services than the current Medicaid-based array of fragmented, unevenly-funded services.

It is not too soon for aging network organizations at every level to begin thinking about how the network can build on its current capacities in preparation for playing a leading role in administering an integrated, comprehensive long-term care benefit. This issue is likely to arise in the context of a larger health care reform debate over how best to contain health care costs while expanding coverage for the large population of uninsured persons and increasing the quality of care. The aging network can help ensure that the long-term care issue is not overlooked as the larger debate unfolds and that the extraordinary assets of the aging network are essential features of any new long-term care initiative that may emerge from the new Administration and Congress.

These developments, plus a clear-eyed view of a future featuring a growing gap between needs and resources should help set the stage for a full scale debate over the proper role of the states
and the federal government in the financing and delivery of long-term care services. The aging network has the potential to play a major role in defining the terms of this debate and in shaping its outcome by moving now to reach a consensus on major policy goals and essential strategies for achieving them. New economic policy and governance (i.e., relationships between the states and the federal government) models, based on enhanced roles for the public and private non-profit sectors, are likely to emerge in the wake of the current financial market crisis and recession and the fiscal crisis of the public sector. Aging network organizations and advocates should be prepared to ensure that these new policy models do not diminish the nation’s capacity to meet the needs of its older citizens in an efficient and just fashion.

Any strategy, however, that may be adopted to overcome barriers to closing the gap between what we do know and what we do in LTC and to creating more balanced LTC systems will confront the challenge of current and projected shortages in the LTC labor force, especially for frontline, direct care workers. These shortages, which are projected to increase sharply over the next several years, threaten to undermine any effort to improve the availability and quality of LTC services if not effectively addressed. Meeting the need, however, for LTC workers should not be seen as a cost issue only. Recruiting and retaining sufficient numbers of LTC workers will require substantial increases in public and private expenditures in the form of increased salaries, benefits, and staffing levels, as well as improved working conditions. On the other hand, however, the need for more LTC workers will provide more employment opportunities for many low-income persons; this side of the LTC labor force equation could be especially beneficial to residents of the Appalachian and Southern Regions where unemployment, underemployment, and poverty tend to be higher than in most other regions of the U.S. Unemployed older workers (those age 50 or 55 and older), who appear to have greater difficulty than younger persons in finding new jobs, may constitute a pool of potential LTC workers that can be tapped through targeted initiatives to recruit, train, and place them in a wide range of LTC jobs. Older Americans Act Title V funded programs, like the Senior Community Employment Program, could provide critical resources for these initiatives.

Full scale maximization of currently available Medicaid HCBS waiver-funding opportunities as has occurred in Oregon and Washington will not be sufficient to meet the level of need for LTC services that will be generated by the aging of the baby boomers. This strategy can certainly create a far more balanced and cost-effective LTC system than most states now provide for the Medicaid-eligible population needing LTC assistance. This approach, however, will not provide the level of assistance needed by the large and rapidly growing population of non-Medicaid eligible low-to-moderate-income elderly with functional impairments.

The population of low-to-moderate-income elderly with LTC needs and without the financial capacity to pay for care on their own will grow by several million over the next three decades. These people must impoverish themselves (spend down) before becoming eligible for Medicaid-supported LTC services and Medicare provides only a limited home health care benefit and up to 120 days of nursing home coverage. Otherwise, this population is wholly dependent on informal care, out-of-pocket resources, or private LTC insurance, if they are among the 9 percent of those 65 plus who have purchased it.
LTC insurance can be made more attractive (affordable) through more beneficial tax treatment (credits) and other kinds of public policy support, but, as noted earlier, its potential to address the LTC cost challenge effectively is limited. Although about three-quarters of the population age 35-59 could theoretically afford LTC insurance, only half now have adequate savings (including home equity). One-third have adequate savings and life insurance and only 20 percent have, in addition, sufficient health disability insurance. All of these risk management provisions probably have greater priority than LTC insurance for most families. Only about 20 percent of those age 60 plus (the population most likely to consider purchasing LTC insurance) can afford LTC insurance and only 15 percent of those age 74 plus. Half of the 65 plus population is already spending, on average, over 22 percent of their income in health care costs. This percent is projected to increase to over 30 percent between 2025 and 2030.

The projected increase in the National Retirement Risk Index (Munnell et al., 2007) described earlier may make LTC insurance increasingly less affordable in the future. Baby boomers need to do far more to build their savings than they need to purchase LTC insurance—this task (increased savings) has been greatly complicated by the stagnant/declining wages of the last 30 years and the loss of equity in their homes caused by the housing bubble. In short, there are many more immediate issues that need to be addressed before thinking about LTC costs and insurance for most people.

But, even if greater savings and the purchase of health insurance are more important, LTC needs and costs are major challenges for many people and the federal and state governments—challenges that will grow steadily for the next several years, putting great stress on the fiscal capacities of both individuals, families, and government. In the future, the Medicaid program can be expected to provide continuing assistance to about 10 to 20 percent of the population with LTC needs who meet the program’s stringent eligibility criteria. LTC insurance may cover a substantial portion of the LTC needs of another 20 percent of the population requiring assistance who can afford the premiums. This will leave at least 50 to 60 percent of the population with LTC needs that will have to be met through out-of-pocket spending and dependence on the shrinking availability of informal care. This is a recipe for the growth of unmet LTC needs and financial distress.

Several European countries are confronting these realities years ahead of the U.S. because their populations are aging more rapidly. And several of them have begun implementing social insurance systems to fund the provision of universal LTC services with a focus on HCBS programs (Gibson, Gregory & Pandya, 2003).

This trend is likely to continue across Europe for two major reasons. First, universal LTC coverage reflects the value that most of these nations have placed on the concept of solidarity among their citizens (a sense of mutual responsibility) social cohesion, and intergenerational reciprocity. Second, universal coverage programs appear to be fiscally sustainable over the next 30 to 40 years with some, mainly Scandinavian countries, experiencing small increases in the already high percentages of GDP spent on LTC (2.5 to 3 percent), and others with relatively modest projected increases of 1 to 2 percent.

Recent efforts to reduce future Medicaid expenditures and the conservative campaign to increase the role of private insurance in paying for LTC indicate that the U.S. is not likely to
join the emerging trend toward universal public LTC any time soon. The United States’ outlier status in terms of LTC and health care policy more generally could change with the aging of the population and shift in the political tide; but for the near future, it would appear that the LTC policy gap between the U.S. and the rest of the post-industrial developed world is likely to widen.

Advocates, policy makers, and the media should begin now to initiate a national conversation focusing on whether LTC financing in the future should rest on a private or public foundation or a new public-private partnership. Public policy changes can improve and extend private insurance. But its benefits are likely to be limited to the top 20 to 25 percent of the income distribution; it has little potential to spread the risk of high LTC costs for the rest. Even if it is accompanied by a universal publicly funded catastrophic benefit, a strategy grounded in private insurance will enhance protection primarily for older people with higher incomes, leaving most people with disabilities at considerable risk of not receiving the care they need. Making private LTC insurance better for those who can afford it makes sense, but making it the centerpiece of the nation’s LTC policy does not.

LTC is rapidly becoming a major policy and fiscal challenge for governments at every level and a growing number of individuals and families across the country—a challenge that has emerged from one of the greatest successes of human endeavor since the 19th century—the longevity revolution. Providing high quality LTC to a growing number of older people is an entirely manageable cost of the longevity revolution, given the great national wealth that the current and future generations of older people have done so much to create.
References:


Polivka, L. (2005, June 13). Coordinated social and health services and give the elderly the maximum opportunity to age in place. Paper presented at the White House Conference on Aging: Washington, DC.


