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# 11. Concluding Comments

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## CONCLUDING COMMENTS

Each of us, at some time or another, is consoled by the belief that some centralized power, be it a person, group or institution, is ably directing the complex systems that serve our society, and thus freeing us from the strenuous task of understanding the vast complexities of our institutions. In a benign and superficial sense, this myth of the "super competence" is akin to Ernst Cassirer's myth of the state for it directly affects our approach to reality. In part it is beneficial because it helps people believe that society is serving them. But the myth has its costs; to the "super competence" we willingly relinquish control. Occasionally, our faith is shaken and we become angry or frightened enough to do something. For example, the Three Mile Island nuclear power plant accident and the attendant efforts by many to comprehend the intricacies of nuclear power production have made us painfully aware that the mechanisms of control are not adequate. Although the multiple problems which exist in our health care system for the elderly do not have the dramatic impact of Three Mile Island, surely they present a comparable policy problem which must be solved to avoid increasing human misery.

The time to consider our futures, who will care for us when we are the sick and the aged, is now! Today, the answer to that question is often the skilled nursing facility, the most expensive way for society to bundle off the chronic health problems associated with aging. As the elderly increase as a portion of the population, the increase in payments for LTC will cause a massive redistribution of wealth, far outstripping inheritance taxes and other mechanisms for transferring wealth from one generation to another. It will eat away at our national savings and the domino effect it generates

may affect the housing industry, industrial investments and other forms of industry reliant upon a ready supply of capital.

Chapter I of the General Accounting Office report entitled, "Entering a Nursing Home - Costly Implications for Medicaid and the Elderly"<sup>1</sup> relates the dizzying evolution of Medicaid and its relationship to LTC. The chapter starts by pointing out that when Medicaid was enacted in 1965 it was felt that it would only give rise to modest increases in expenditure beyond the \$1.3 billion cost of the vendor payment programs it replaced. Medicaid was activated in 1966; by 1968 the cost was \$3.5 billion; by 1975 it was \$12.5 billion; and by 1978 it was \$18.6 billion. In 12 years Medicaid expenditures rose by 1330% above the 1966 base of \$1.3 billion. Even accounting for inflation in the health area, the increase is in excess of 1100%.

There are several reasons for this growth in expenditure but the major one is the coverage of nursing home care. A full \$7.6 billion, or 41% of the 1978 Medicaid expenditure is for LTC. The Institute for Medicaid Management projects that the Medicaid expenditure for LTC should reach \$9.4 billion by 1984.<sup>2</sup> Given the track record for estimating future expenditures in this area, one might guess that even this figure represents a rather conservative guess.

If this expenditure trend continues, LTC will eventually become a burden our society will be unable to bear. By the early part of the 21st century, as the children of the post World War II baby boom move into the 70's, the level of expenditures will be so high that services may have to

<sup>1</sup>General Accounting Office, Entering a Nursing Home - Costly Implications for Medicaid and the Elderly, November 26, 1979, pp 1-15.

<sup>2</sup>Institute for Medicaid Management, Data on the Medicaid Program: Eligibility/ Services/Expenditures, Fiscal Years 1966-78, DHEW, Washington, D.C., 1978.

undergo a forced reduction at the very time when consumer demand will be most intense. If we cannot control the LTC system within the next twenty years, the stage will be set for a significant decrease in the living standard for the elderly, the possibility of passive euthanasia as a programmatic necessity, and the probability of wide spread misery for our elderly.

Not only is LTC excessively expensive, but the system which has evolved to care for the sick and the aged is excessively complex. At the root of the problem of escalating costs and control is our health care policy process itself. Historically, the "Great American Policy Compromise" has involved giving the political liberals their pet programs and helping the conservatives lick their political wounds by letting distant state governments run many of the programs. Many "short circuit" devices have been tried to foil the great policy compromise. Lyndon Johnson's "creative" federalism sent aid directly to the distressed cities and even to community groups looking for innovation and effectiveness. Richard Nixon's "new" federalism gave local jurisdictions new freedom within the framework of bloc grants so that they might do what the idiosyncratic local political structure might want most. However, both left unchanged the policy compromise struck in 1965 with regard to health care. In this compromise, most of the health care power went to the states.

In response to the confusion and disarray caused by the federal/state compromise, the PMS has tackled the very basic questions of LTC - who shall administer, finance, structure services, regulate and allocate values for LTC? Our answer is not yet another "new" federalism or a return to the

halcyon days of state independence. Our conclusion is that we must reassess the LTC system in its entirety, considering all incentives and values.

As Sandra Caccamise has stated in her chapter on the administration of LTC, the present structure depends upon an unenthusiastic "partnership" among federal, state and local units of government. In reality, LTC is rendered by governments, by the private non-profit sector and by the private sector. To the states go the tasks of partially funding, regulating, setting standards, and encouraging innovation for LTC. Although the federal government assumes the role of technical advisor for these functions, its real task is to provide dollars.

The next thirty years of LTC regulation will see the federal government breaking out of the pattern set by the "Great American Policy Compromise"; it will dramatically increase its authority and powers. While it is improbable that the diffuse LTC system could be federalized, some of the PMS seminar participants saw greater federal participation even to the extent of direct participation in administering a small percentage of special purpose and pilot long term care facilities. The federal role and span of control will increase, but so will that of the states. New York State is committed to the regulation of LTC perhaps to a greater extent than most states and will become a national model. The PMS seminar noted that the level of state intervention in long term care will escalate, especially as more and more legislatures struggle to understand and get control over their own Medicaid programs.

The increasingly important roles of the federal and state governments is merely part of the present trend. We hope to see other administrative

structures eventually replace both the state and the federal government in LTC because both represent illogical outposts from which to run LTC. Various levels of government inherited LTC by default, an uneasy partnership developed, growth was uncontrolled, costs zoomed - the system was out of whack primarily because no one was clearly in control. This situation leads us back to the all important question, "Who will take care of me in 2020?"

We ask you, the reader, to speculate upon the solutions presented here. Perhaps, the answer can be found in one of the ideas included in this paper. Perhaps these solutions can provide a starting point, a base upon which to build sound cost containment strategies, levels of care, central screening mechanisms, and reimbursement procedures. Perhaps we will have to find other solutions, not suggested herein. We feel we have fulfilled our responsibilities just by raising the question of our needs with regard to LTC. We propose no miracles in this modest little monograph, but we hope that when the bell tolls for the LTC of the post-war baby boom, it will not signal the bankruptcy of society also.