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STATEMENT OF

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ON

LONG-TERM CARE

BEFORE THE

SUBCOMMITTEE ON HEALTH

UNITED STATES SENATE

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

We are pleased to be here to talk about GAO's work in long-term care over the past several years (see Appendix). As you noted in your announcement for this hearing, "one of the most difficult social issues facing our Nation is to determine how best to provide for the long-term needs of our frail elderly and disabled populations." Currently there is no coordinated national policy that promotes both adequate and efficient long-term care services.

The elderly and their families often encounter numerous difficulties when they look for long-term care services. As we

determined from one study (GAO, 1979), they are likely to find that

--there is a lack of information about the services available,

--community services essential to remaining at home may not exist,

--there is often a lack of coordination among public and private community service providers,

--eligibility for services varies across institutions and across states, and

--professionals may tend to recommend nursing home placement not because it is appropriate but because they do not have the expertise or time to arrange for community care.

Community-based long-term care is often expensive and may be unaffordable to many. The elderly in need of services often find that the only source of help they can receive is nursing home care subsidized by Medicaid.

Because of these problems, there is considerable interest in the government's liberalizing eligibility and the coverage of services to insure the expansion of community-based home health care. Revisions to the present system are also being proposed in response to

--an increase in health care demand stemming from the growth in the size of the elderly population and reduction in the ability of families to provide care to aged parents and grandparents,

--the new dominance of chronic disease as the major health care problem among the elderly,

--efforts to reduce high government expenditures for nursing homes and hospital care, and

--a desire to increase the independence and improve the physical and mental well-being of the elderly.

Some recent GAO reports (GAO, 1982 and 1983) may be of use as you consider what changes are needed in the payment and provision of long-term care services to the chronically ill elderly. Let me briefly describe our findings from two studies--one on home health care and the other on nursing home care.

HOME HEALTH CARE STUDY

Our study of home health care (GAO, 1982) found that an expansion of community-based benefits would provide valuable services to the nation's elderly. We found evidence that individuals who received expanded home health care services lived longer than those who did not receive these services. Those who received them also reported feeling more satisfied with their lives. However, we found that such expansion would increase the numbers of people eligible for and receiving publicly supported care. And, as eligibility and services expanded, this would necessarily mean growth in the nation's overall health bill. Nonetheless, we had expected to find that some of the increased home health care costs could be offset if there were savings from reduced nursing home and hospital use.

But in our review of home health projects, which offer a wide array of community-based care to the chronically ill elderly, we found that home health care services have not conclusively reduced either institutionalization or total service costs. While one might intuitively expect that providing home health care services to people in their own homes would be less expensive than providing nursing home care, there are several reasons why an expansion of home health care may not reduce overall health care costs:

1. Two to three times as many chronically ill elderly live in the community as live in nursing homes. Making home health care services more widely available might mean that some people living in the community who are eligible for the additional services might use them because they are as disabled as some nursing home residents. The additional services would probably be beneficial to them but would also increase overall health care costs because more persons would be served.
2. Most of the long-term care given to the elderly today is provided informally by relatives. With broader coverage and eligibility for a wider range of home health care services, families might substitute publicly subsidized services to reduce their own burden.
3. The unmet demand for nursing home beds is substantial in some geographical areas of the country. This means that while some individuals may not enter nursing

homes, savings may not be realized in the short term if the chronically disabled elderly who are waiting in hospital beds or in the community for nursing home care are placed in beds made newly available by expanded home health care.

4. Finally, because home health care services are provided in individual homes, it is difficult for the price of such care to be competitive when extensive services are provided in nursing homes where many individuals can be served at the same time.

While these findings indicate both that home health care is beneficial and that costs are likely to increase, perhaps the important issue here is that community-based long-term care services will continue to grow. This is because most individuals and their families prefer to avoid institutions and desire instead a wide range of options in long-term care in addition to nursing home services. The increasing number of initiatives and programs in long-term care at the state level are in part a response to this public preference for obtaining needed services outside institutions. Given this pressure and the potential costliness of expanding home care, attention to developing efficient means of providing these services is essential.

NURSING HOME STUDY

Besides the pressure from popular support for expanded community-based long-term care services, constraints on the availability of nursing home beds may add to the pressure to

increase services. These constraints were identified in another GAO report, available today, in which we reviewed nursing home care across the states (GAO, 1983). The government spends more on nursing home care than on any other long-term health care service. Because Medicare and private insurance pay for only a negligible portion of this care, Medicaid, a state administered and federally supported program, has become the primary payer. National estimates of its coverage range from 48 to 75 percent of all nursing home residents.

In our study of trends in nursing home services over the last several years, we concluded that nursing home bed supply may not have kept pace with the increase in the population most likely to use nursing home care. Available estimates of the growth in elderly population cohorts show that the number of persons age 65 and older grew 2.4 percent a year in the middle to late 1970's and bed supply grew 2.9 percent. However, the biggest users of nursing home care, those age 85 and older, grew an estimated 4.5 percent a year. These data suggest that bed supply did not increase fast enough to serve the same proportion of elderly who have been served in the past. We also found that the availability of nursing home services varies widely from state to state. Some elderly are unable to gain access to nursing homes, and others appear to use them unnecessarily.

We found two conflicting trends in the available data on nursing homes. The first trend, based on data from two national surveys and a detailed data base on all Minnesota Medicaid nursing home residents, involves a growing intensity of

services. The elderly who now reside in nursing homes are becoming increasingly disabled and dependent, and the number who may need to enter them in the next decade is likely to increase. Unless major breakthroughs in the treatment of chronic diseases occur, extended life expectancies, with greater likelihood of chronic disabling diseases, and a reduced number of family members able to provide informal care will lead to a net increase in the population most likely to need intensive nursing home services. Further, if community-based services postpone or prevent placement in nursing homes for some elderly, nursing home residents are likely to be more dependent and have costlier care needs than in the past.

The second trend, conflicting sharply with the first, involves the effort by most states to keep their Medicaid costs down, despite high nursing home occupancy rates and growing demand for services. The states are making this effort because Medicaid expenditures for nursing home care constitute a large component of the states' Medicaid budgets and have increased at high rates in the past. Virtually all the states have had problems financing this service and their efforts to reduce costs tend to focus on ways of limiting nursing home reimbursement or the supply of beds or both.

While the states are attempting to cut their costs by limiting the availability of nursing home services, recent changes in Medicare's hospital reimbursement system may sharpen this conflict. Medicare's new diagnosis-related group (DRG) payment system for hospital care, with its built-in incentive to

reduce lengths of stay in hospitals, may place greater pressures on the use of a limited nursing home bed supply. Hospitals may attempt to place more patients in nursing homes and in home health care as they try to discharge patients earlier than they have in the past. However, nursing home beds may not be available to meet this new demand, which would, in turn, increase the need to expand community-based services.

CONCLUSION

To sum up, I have drawn attention to several factors that have clear significance for long-term care policy. First, and perhaps paramount, most elderly and their families prefer to avoid institutional care and would rather receive a range of services in the community. Second, there is a growing elderly population, with an increasing likelihood of disabilities, who will be in need of long-term care services. Third, many individuals like those who have appropriately used nursing home services in the past may not be able to find nursing home beds, because of the states' efforts to limit the supply of beds and because of the effect of Medicare's DRG system on expanding the demand for nursing home services. These individuals may need to rely on an expanded array of home health services. Fourth, and finally, a new group of individuals may be seeking expanded home health care services as a result of the changes in Medicare's hospital reimbursement system.

An expansion in the availability and use of community-based services is likely to increase public health expenditures. This is probable because of reasons I have already mentioned,

including the following: (1) more individuals are likely to use these services, (2) many of these services would now be paid out of public funds whereas historically they were provided by the family, and (3) providing expanded community-based services will not necessarily result in institutional savings.

With the expected expansion of both demand and costs for long-term care and the concern that many persons who are in need of long-term care may have difficulty in obtaining the services that they need, it is imperative to identify how these services should be organized and reimbursed to insure maximum efficiency and effectiveness. Our studies have found that basic program data on long-term care services are inadequate. Data on the care needs of the persons who are served and not served in long-term care settings and on the costs of these services are generally outdated, unreliable, or unavailable. Until we have a better understanding of the current delivery and reimbursement of long-term care services, it will be difficult to translate the findings of current long-term care research projects into effective national policy.

While demonstration projects are important in testing untried alternatives, we should recognize that there is great variety in what the individual states are already doing under Medicaid and other state programs. For example, there is a need to evaluate the several state preadmission screening programs that have been in operation for several years as well as alternative methods of reimbursement for the care of the very dependent elderly in nursing homes. The development of data on

and an analysis of their experiences could yield considerably useful information.

We believe that the analysis of long-term care experiments should focus specifically on four areas: (1) the characteristics of the persons who are most in need of long-term care, (2) the types of services that long-term care should encompass and who should provide them, (3) the methods of payment that will provide services the most efficiently, and (4) the mechanisms that will allow the maximum of informal support from families and friends. In the evaluation of new proposals for providing long-term care, these four areas must be addressed if we are to derive the kind of information that we need in order to develop a system that is adequate, efficient, appropriate, and equitable.

MAJOR GAO REPORTS ON LONG-TERM CARE

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Preliminary Findings on Patient Characteristics and State Medicaid Expenditures for Nursing Home Care, GAO/IPE-82-4, July 15, 1982.

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The Well-Being of Older People in Cleveland, Ohio, HRD-77-70, April 19, 1977.

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