Long-Term Care: The Present (what we do, what we know) and Future (the context)

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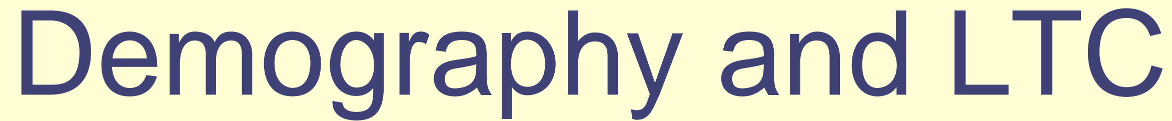


Demography and LTC

- 35 million 65+; 70 million by 2035
- 85+ (3-fold increase by 2030)
- Less impairment (mainly IADL)
- Florida/U.S.

What we do in LTC

- Informal caregiving—70-75% of care provided; little formal support, big burden (dementia); role of women (est. value $200 billion)
- Formal, publicly provided care (est. $100 billion—state, federal and local dollars; $60 billion from Medicaid—80% for institutional (NH) care (Medicaid bias); 15-20% for HCBS

What we do (cont'd)

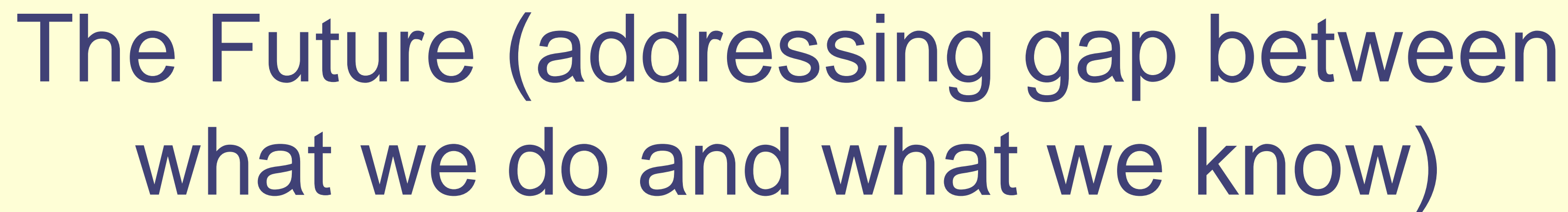
- Formal, private-pay ($5-10 billion, about half is insurance)
- NH use has declined since 1994 with growth of AL (private-pay) and in-home care (Medicaid waiver) and slower growth of slightly less impaired 70+ population—NH census has declined from 1.65 million to 1.45 million
- HCBS expansion has been slow in most states (esp. Florida) and lags *far* behind DD

What we know about LTC

- The elderly and 50 to 64 age groups (AARP) overwhelmingly prefer HCBS to NH care
- HCBS, including CRC, is, at least, as cost-effective as NH care for most LTC recipients—the research is not conclusive about superior C/E of HCBS, but there are no findings supporting the C/E of the current NH dominated LTC system

What we know (cont'd)

- A few states have made substantial progress in balancing their LTC systems (AZ [ALTCS]), OR (48%), WA (45%), CO (35%) and they have been able to serve more people at no greater cost
- These states have common features which are largely missing elsewhere, esp. Florida
  - A fully integrated LTC system (HCBS & NH), with simple entry process (I&R, assessment, care planning and management). The state controls funding and sets policy and local agencies deliver services, which are highly individualized (assessment-based)
  - Commitment to maximizing Medicaid HCBS waivers, like DD



The Future (addressing gap between what we do and what we know)

- States will probably continue the slow growth of their HCBS programs with increasing emphasis on AL and CDC (recent research), but there are not likely to be many Oregon-like breakouts (balanced systems) for the next ten years or until the aging baby boomer generation begins to exert political pressure, LTC becomes a powerful gender justice issue and caregiving (formal and informal) labor force shortages become severe (CDC—paying caregivers), because:

The Future (cont'd)

- absence of strong advocacy and continuing, though declining, NH industry assistance.
- State and federal fiscal crises—which are growth and fiscal policy dependent. Relative and absolute funding for HCBS vs. NH care (entitlement issue) vs. all other needs (education, non-LTC health, crumbling infrastructure), will be greatly affected by the current tax phobia and the emerging neoliberal *market state*

The Future (cont'd)

- Increasing focus on integration of LTC services and acute care with LTC and an emerging competition between two models

- a proprietary HMO vs. aging network-controlled managed LTC system—the privatization priority of the market-state favors the former (FL experience) along with greater emphasis on individual (family) responsibility—out-of-pocket (like acute care insurance and Medicare) and private insurance (the 20% solution)

- Increasing research focuses on quality-of-life issues, less on C/E—potential threat of the cost/benefit perspective already evident in neoliberal environmental and regulatory policies of the market-state framework and the social philosophy of the intergenerational conflict advocates (social compact vs. hyper-individualism)

The Future (cont'd)

- **Ethics and politics of public policy**. LTC policy and practice will be shaped more by the erosion/renewal of a public ethic, based on concepts of social justice than economics—on the extent to which the market-state becomes dominant and declining revenues are used to fund a militarized foreign policy and surveillance state at home and social welfare expenditures are curtailed and lose legitimacy, the public is de-politicized and fractures along cultural, generational, socio-economic (wealth gap), gender and ethnic lines (loss of solidarity).

The Future (cont’d)

- In short, the socio-political, cultural, philosophical (ethics) context is critical to the future of LTC policy and practice and all other aging-related policy issues.