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MEDICARE, MEDICAID AND THE AVAILABILITY OF GERIATRIC RESIDENTIAL ENVIRONMENTS IN THE UNITED STATES¹

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It has become a cliché to refer to the 20th Century as a time of rapid change. One of the most dramatic – although not always highly visible – changes which has occurred over the past seven decades has been the growth of a relatively large aged population in virtually every developed nation. The interaction of various causal factors have resulted in the aged increasing from three percent of the total U.S. population to almost ten percent in little more than a single half century.

This development of a large aged population has been followed by recognition of certain social problems related to age, and the development of various public policies and social institutions to deal with those problems.

The most fundamental expression of public policy related to the aged in the United States is the Social Security Act, which provides for the Social Security program, the Public Assistance program including Old Age Assistance, Medicare coverage for the aged, and Medicaid coverage for certain welfare beneficiaries including the aged.

While there have been important amendments to the Social Security legislation over the years, few have been more significant than the introduction of health care coverage. Medical vendor payments were first allowed under the public assistance program in the early 1950s. In the early 1960s Congress gave individual states the option of establishing special Medical Assistance for the Aged programs and many did. However, the most significant health component of Social Security came in 1965 with the passage of Medicare and Medicaid – Titles XVIII and XIX.

It is our intent in this paper to explore the effects of these two pieces of legislation on the small portion of the human services delivery system specializing in care of the elderly. While the relations between the government and the medical profession and the effects of Medicare on hospitals and other subjects have received widespread attention, it seems to be frequently overlooked that medical assistance programs whose primary thrust is to the aged could be expected to have major importance for that portion of the service delivery system most directly available to the aged.

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The central focus of this paper is on public policy and its effects on the service delivery system. The study of public policy can be approached from many perspectives. Theodore Marmor, in a recently published study of Medicare suggests three possible approaches: the rational approach, the view of public policy as the outcome of organizational processes, and policy as the result of bureaucratic bargaining. Since we are less interested in process than in the content of policy, our approach is essentially rational. The study involves a rationally conceived continuum of services for the elderly which incorporates combinations of residential and service components which we call the Geriatric Residential Environments continuum.

While public policy study in the area of services to the elderly might also be concerned with regulatory mechanisms, quality control systems and related matters, we have limited ourselves here to the mechanisms which might be expected to have an impact on the distribution of Geriatric Residential Environments, which in addition to nursing homes, we define as personal and boarding care homes and public housing for the elderly. Our study focuses on distribution, or availability of these services on the assumption that greater access to service is a principal thrust of public policies in this area, and that services must exist, or be available, in order for them to be accessible, and therefore used.

In each of the types of facilities studied, existing or developing public policy plays an important role either in making services available – through construction loans, etc., - or in making services accessible – through vendor payments, insurance, etc.

The principal assumption of the Medicare legislation – both Medicare and Medicaid – appears to be that money is the best available way to purchase additional access to health care services for those presently unable to “get in.” Although there is much public rhetoric on the ways the Medicare legislation can (or should) increase the quality of health care, this is, in essence a peripheral issue. The issue is peripheral because qualitative regulation in the present programs appears more a matter of accounting control than a deliberate effort to raise delivery system quality. Likewise, the availability of services, either in terms of support for the existence of a balanced national distribution system, or in terms of individual access (other than financial to the system is not an evident area of concern in Medicare or Medicaid. Yet, even though these issues are not dealt with in the original policy, whether or not there have been efforts in these areas are frequently asked questions by both policy-makers and researchers.

Our intention is to leave the question of quality of care to others and deal with the distribution or *availability* aspects of the delivery system. It would appear that Medicare and Medicaid have raised two important questions in this area:

- Have Medicare and Medicaid actually facilitated the availability of services to individual aged beneficiaries?

In other words, is the health care system more accessible to the aged today than it was in 1960, and is this increased accessibility related to Medicare and Medicaid?

- Whether or not there was intent, did the Medicare legislation bring about changes in the delivery system?

Are more health care services for the aged in existence today than before 1965, and if so, were Medicare and Medicaid primary causal factors in bring about such increases?

To examine these questions, state data were collected from a variety of state and federal sources on nursing homes, nursing home beds, personal care homes and public housing units.

Conventional wisdom on these questions suggests several things. First, it is widely believed that Medicare generated great growth in the nursing home industry, and that much of the new capital was brought in by corporate chains of homes attracted by the prospect of large, virtually guaranteed profits. Our research, based on data gathered from state health and welfare departments and supplemented with interviews with nursing home operators, Public officials and representatives of the national nursing home associations suggests that this is only a partial, and not totally accurate, picture.

There *has* been dramatic growth in nursing homes during the past few years, much of this growth *was* in the private, for-profit sector of the industry and nursing home chains *have* entered the field in recent years. However, not all of these events can be attributed directly to Medicare and Medicaid.

There can be little doubt about the growth in the availability of nursing home beds. Figures gathered by an annual survey of the states conducted by the American Nursing Home Association, for example, suggests that the number of nursing home beds in the United States has more than doubled since 1960, and currently stands in excess of 750,000 beds. Likewise, the number of nursing homes has increased from 9,500 in 1961 to nearly 15,000 today.

Data suggest that this growth has been surprisingly uniform through the country during the past decade. Although the total stock of beds was not doubled in every state, increases were recorded in all of the 43 states for which we have data. In no state were there fewer beds in 1969 than in 1960.

Our data also suggest that there was relatively greater growth in urban (SMSA) areas than in non-urban areas, although the difference was not large. The mean percentage of nursing home beds located in urban areas, for example, increased from 31.7 percent in 1960 to 38.9 percent in 1969. However, this should be understood in view of the fact that gains in urban beds were recorded in all states, while there were gains in non-urban beds in all but three states.

Likewise, the appearance of corporate nursing home chains during the 1960s should not be interpreted as the end of the nonprofit home by any means, although the proportion of total beds under proprietary management nationally increased during the decade from 50.9 to 64.8 percent. Once again, it appears to be a case of growth in both sectors, while growth in

proprietary beds occurred at a relatively higher pace. While the increase of beds was fairly uniform, the *percentage* of nonprofit beds increased in only five states.

Careful plotting of growth patterns in individual states during three separate periods as well as for the entire decade strongly supports the view that the changes in the industry in recent years are, for the most part, part of a continuing growth pattern rather than the result of any direct effect of Medicare and Medicaid.

Growth in California, for example, which accounts for nearly 10 percent of the nation's aged population and 10 percent of the nursing home beds, illustrates this well. There were 17,400 nursing home beds in California in 1960, 43,500 in 1965 and 77,200 in 1969. What this means is that while the number of beds in California increased some 440 percent after 1961, the growth is surprisingly evenly distributed over the entire period. There simply was no great increase in the number of nursing home beds in California or any other state following the passage of Medicare which probably would not have occurred without Medicare.

Another important pattern in the growth of nursing homes which can be discerned from our data is the rapid increase in the *size* of individual homes. Our data indicate a national average of about 33 beds per home in 1960. By 1965, the data show this figure at 43 beds per home and a further increase to 59 beds per home in 1969. Such aggregate national figures, however, obscure wide spread differences in the size of nursing homes. Florida had the highest state average in 1969 at 80 beds per home. And homes in New York and Pennsylvania (79 and 78 per home respectively) tended to be 2 ½ times as large as those in the New England states of New Hampshire (28), Maine (31) and Vermont (32). Note also that average size of nursing homes in all three of these states was lower in 1969 than the 1960 national average.

Perhaps the most significant factor in the growth of nursing homes during the 1960s, however, is the apparent tendency for the supply to begin closing the hypothetical gap with demand or need. There are, at present, no very good measures of the need for nursing home beds in any given area. However, the number of beds available per 1,000 elderly persons in the population does offer a basis for comparing crude supply/demand relationships. This assumes, of course, that demand will increase with population growth.

There were about 22 beds per 1,000 elderly persons in in the United States in 1960. By 1965, this ratio, taking into account population increases, was at 35 beds per 1,000 elderly and by 1969 the figure was 43 beds per 1,000 elderly – nearly double the 1960 figure. Once again, this increase was in all states a steady, constant rise, rather than a sudden, dramatic surge following 1965 and attributable to Medicare and Medicaid.

To more accurately gauge the meaning of these changes in the nursing home industry, we can employ the Geriatric residential Environments continuum to compare similar developments related to different types of facilities. The principal assumption of the GRE is that, in addition to care or treatment, a second primary benefit available from nursing homes and other related facilities in housing or shelter. In contrast to a doctor's office or the intensive care wing of a hospital, people *live* in a nursing home, often for months or years. Consequently,

it is unrealistic to view medical or quasi-medical health care as the only major benefit provided by nursing home. In the same vein, the Medicare and Medicaid programs have brought on the development of a national system of home health care, which further blurs the distinction between residence and treatment settings for the aged. Thus, although housing and health policies are treated as separate categories, they are obviously interrelated in the case of the elderly, where treatment setting such as nursing homes and personal care facilities also provide residential living and boarding homes housing for the elderly and even private residences may become de facto treatment settings.

Although this concept might eventually be useful in construction cost-benefit studies on a comparative basis and for other policy-relevant purposes, we are employing it specifically to compare patterns of growth , location and other descriptive factors.

Analysis of our data, for example indicate that there were significantly fewer personal and boarding care homes per 1,000 aged persons in all states than there were nursing home beds. While there were only a national average of 14 personal and boarding care beds per 1,000 elderly in 1969 (compared to 33 nursing home beds). Further, there were only 5 public housing units for the elderly at the same time. It should be noted that public housing units were chosen in the belief that they represent the single largest category of specially designed housing for the aged available in the nation, and further that we have assumed that a unit of public housing is roughly comparable to a nursing home bed because of the very high incidence of single occupancy units in public housing for the elderly. Note, however, that even if every single public housing unit for the elderly housed only couples, there would still be fewer older people living in such housing than in personal and boarding care, and less than a third as many as in nursing homes.

The growth of public housing for the elderly, on the other hand was very dramatic, and presumably due almost entirely the adoption of federal housing programs and local government willingness to use them. There were very few available public housing units for the aged in 1960 because the program was only started in 1956. The number of units available to the aged drew from about 1,000 units in 1960 to almost 93,000 units at the end of 1969.

In comparing these data with the growth patterns experienced in nursing homes, several conclusions are suggested: First, increases in the supply/demand ratio in nursing homes were not achieved at the expense of declines in other types of services in the continuum. Secondly, it appears that in some way the availability of federal funds to nursing homes and public policy and lack of similar funds to personal and board care, is an important factor in the differential rates of development of these various facilities.

The question, of course, is which federal funds affected what kind of growth. In line with our earlier conclusion that there is no evidence to support the hypothesis that nursing home growth came about because of Medicare, there is also some evidence to suggest an explanation for this. Although Medicare may be a significant factor the for aged in terms of payment of doctors' fees and hospital charges, it is relatively unimportant in the case of residential long-term care because of the limit on the number of days for which payment can

be made under Medicare. As a result, only an estimated ten percent of the total nursing home patient load at any given time is paid for by Medicare, according to industry spokesmen. Medicaid, however, must be viewed as a major factor in the economics of long-term care because estimates set the proportion of nursing home patients receiving Medicaid may be as high as 50 percent. Medicaid is an extension of the older Medical Assistance for the Aged (MAA) program and also of the original precedent for medical vendor payments established in the early 1950s. Therefore, it would appear that to the extent that federal dollars are a major factor in the growth of the industry, it is the relatively lesser known Medicaid, and not Medicare, that must be treated as the most likely cause.

This brings us to the question of what actually did cause the increases in the availability of nursing homes in the 1960s? In our view, there are several probable explanations. First, it may have been the economics of the marketplace. More than half of the available beds are under proprietary management and the decade just past was the single longest uninterrupted period of economic growth in the nation's history. The nursing home industry may have been responding to the general economic boom.

Or the growth may have been caused by a growing need for this type of service. The aged population continued to increase during the decade and presumably the number, if not the percentage of aged persons needing nursing care also increased.

It could also be the result of social and political actions at the state and local level. States license nursing homes and have considerable discretion in carrying out public assistance programs. Consequently, the opportunities for affecting growth in the industry may be particularly great at this level.

It might have been the result of some kind of macrosocial shift in values regarding the nation's older population; a kind of subtle shift in public opinion toward providing greater support for the aged. The 1960s were after all the time of a White House Conference on Aging, of substantial policy debate of age-related issues of the creation of many state aging agencies and the federal Administration on Aging, and of course, the national debates over Medicare.

Or, it might have been the result of numerous other factors seemingly unrelated to nursing homes or older people.

In an effort to deal with these questions, a stepwise regression analysis was performed on the data. Stepwise regression is a computer assisted statistical technique for determining, roughly speaking, the "cause" (or the possibility of multiple causes) of a given dependent variable – in this case the growth of nursing homes. The technique involves selection from a list of independent variables the single variable with the highest correlation to the dependent variable. This is the first step. In the second step, the computer selects the *two* variables with the highest correlation in combination. This process continues with three, four, *n* variables until all have been included in the model. While this procedure is used frequently in the construction of sophisticated prediction equation, it works equally well for our purposes; for providing a rank ordering of the importance of the variables together with an estimate of the total amount of

variance in the dependent variable that is explained by the various variables representing different causal factors.

The rank ordering of causal factors explaining the growth of nursing homes over the entire decade of the 1960s include the following factors as most significant:

- The political climate of the state (as measured by the vote of the state's senators on Medicare).
- The growth of the elderly population of the state during the decade.
- The growth of individual personal income in the state during the decade (as a market demand factor)
- The scope of Medicaid coverage adopted by the state (as a further indicator of state political factors)

As an explanation of the final factor, under Medicaid provisions, states are given the option of providing coverage of "indigents" only, or of also covering "medical indigence" which amounts to a more comprehensive form of coverage. Those states with the broader coverage showed greater responsiveness to the aged than those with narrower coverage. Listing of the factor here indicates that, in combination with the other factors, those states tended also to have smaller nursing home population growth.

All four of these factors were significant at the .05 level, indicating statistical significance. Together they account for a little more than one third (34.98) of the total variance observed. In combination with the other variables (which were determined to be greater than the .05 level), all variables examined account for slightly more than one half of the total variance in nursing home growth in the states. (Note: given that this is a study of the complete population of states, rather than of a random sample of a larger population, the test of statistical significance is more an estimate of the strength of relationships between two variables than of the probability that the sample is an accurate measure of the population.)

What was also interesting from the stepwise regression analysis, is the nature and direction of the relationships between the growth of nursing homes and the various political and social variables. The relationship between the growth of the elderly population and the growth of personal income are both positively correlated, suggesting that some portion of the growth of nursing homes is due to increases in the aged population and in the ability of older people or their families to pay for care. However, individual correlations between the Senate votes on Medicare and the type of Medicaid coverage offered in a state and the growth of nursing homes during the decade are both negative. (-.37 and -.306 respectively). What this appears to mean is that to the extent that Medicaid did affect the growth of nursing homes it did so in a "redistributive policy" manner – generating greater growth in those states with relatively fewer nursing home beds to begin with, and relatively less growth in those areas which were comparatively well off at the beginning of the decade. This is in contrast to the "distributive" relationships between nursing home growth and both the rise of personal income and increases in the size of the aged population. Those states that made the greatest gains in

income over the decade also scored comparatively great increases in the number of nursing home beds than those states which fared less well.

Conclusion

The major findings of this study can be summarized as follows:

1. There are important reasons for examining the growth of nursing home beds not only as a health care resource, but also as a form of residency or housing.
2. There was substantial growth during the 1960s in those component of the Geriatric Residential Environments continuum which received federal financial assistance (nursing homes and public housing) and considerably less growth in those segments which did not (personal and boarding care homes).
3. Medicare had no demonstrable effect on the availability of nursing home beds, in terms of the total system, despite widely publicized and presumably non-typical examples to the contrary.
4. Medicaid, in conjunction with previous medical assistance programs available nationally, appears to be an important factor promoting the growth of nursing home beds, in particular, in underdeveloped areas.
5. Future programs of federal financial assistance should focus on the probably effects on related service delivery systems. In particular, attention should be focused on the developing Intermediate Care Facilities and the probably housing effects on other components of the Geriatric Residential Environments continuum.