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07. Appropriate Levels of Care

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APPROPRIATE LEVELS OF CARE

Consumers of long-term care are primarily the elderly, whose numbers are approaching 25 million; they comprise almost eleven percent of this nation's population.[1] They experience higher incidents of chronic disease and long term illness, with the most serious health care problems occurring in those over 75.[2] These health care problems are usually costly because of the need for hospital and nursing home care, as well as other forms of intervention, and the unavailability of suitable, less costly alternatives, particularly in rural areas. In addition, these problems are compounded by lack of mobility, poor nutrition, lack of primary care and other elements often related to limited financial resources.

One approach to the problem of costly yet often inappropriate and inaccessible long term care is an increased federal or state role in directing, controlling and financing long term care services. Major strategy elements would include increasing the available range of services, achieving an appropriate mix of services, relieving part or all of the existing financial burdens on states and localities and stemming current cost escalation through appropriate utilization. Further analysis of this problem, and of potential strategies and solutions, requires a long-term care policy framework. A policy framework would set forth certain values, standards and directions as a means of specifying current problems and measuring the adequacy of potential solutions. Such a policy should include at least the following elements: (1) Choice among appropriate care alternatives and maximum functional independence consistent with need and cost effectiveness; (2) Availability of comprehensive evaluation and re-evaluation of patient needs. Also, given that needs and service delivery options vary from locality to locality, a policy governing long-term health care should recognize the need for a degree of local determination and participation and for plurality

in service models and sponsors.

Services And Levels Of Care

Implementation of the first part of a long-term care framework, choice among appropriate care alternatives, requires the development of health and health-related services with levels of care of sufficient range and distinction to enhance patient care and progress towards the highest level of functional independence. Care along this continuum of services should also recognize and account for the interrelationships of health and other human needs such as psychological well-being, socialization and emotional stability, and balance administrative and logistical limits as well. Such limits may apply in view of cost effectiveness standards or, in reality, the requirements of good patient care.

A spectrum of services, varying in degress of intensity, is necessary to meet the needs of individuals requiring long-term care. In this regard, Eric Pfeiffer noted that "no well-established definitions had been made of what was meant by 'services'. Some existing definitions of services are related to a specific provider, such as a nursing home, a day care center, or a mental health hospital. Analysis of these so called services indicated that they were not separate and distinct services but they constituted complex service packages.... Not all nursing homes provided the same set of services."[3] The following service elements could be included:

- nursing care
- therapy
- dietary
- socialization
- recreation
- chore service
- friendly visiting
- home modifications
- transportation (including non-health related)

- psychological
- social service
- medical equipment
- home health aide (dressing changes, bathing, etc.)
- respite care (allowing brief rest for those caring for someone at home)
- day care (services at a central site that enable one to remain at home)
- housing or rent subsidy
- support for thefamily (who is caring for an individual)
- dental care
- eye care
- preventive medical care (including primary care)

These services may be available at various levels of care. Kathy Powers, a Rochester Health Planner, describes and elaborates on levels of care.

> Levels of Care refers to the spectrum of residential care settings in which various degress of medical, nursing, social, domiciliary and support services are available. These settings include hospitals and other institutions, supervised homes, and independent living.
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> Increasing numbers of studies reflect public interest in the need to appropriately meet the care needs of the elderly and disabled. A number of people feel that more emphasis needs to be placed on the functional ability of individuals rather than on a person's disability, diagnostic category, or disease. Many times in spite of the long lists of medical problems, the elderly or chronically ill person demonstrates an ability to compensate which is remarkably efficient and the individual can function within normal limits. When intensive services are necessary, it is desirable that the level of health care services received is appropriate for the health care needs of the individual.
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> The services provided to meet client needs depends on the availability and accessibility of services in an area. The more comprehensive the level of care the more costly. For example, the acute hospital provides the most comprehensive and costly level of health care. Institutional care with built-in services is more costly than providing some individual services to meet client needs in their home. Many times clients do not need all the built-in services that an institution may offer and therefore it is imperative that the client needs be assessed and reassessed to insure the appropriate use of limited health care resources. As a result, the needs of the individual can be met in the lowest level of care rather than the individual having to conform to the institutional services available.[4]

The Genesee Region Health Planning Council developed level of care definitions as part of a methodology to estimate bed needs. They are described and illustrated here to demonstrate two vitally important points in arguing for a

full range of services. First, the levels are discrete in order to distinquish the problems and limitations of the individual and the support required to enable that individual to function. Second, the levels represent increasing functional independence for the individual. Thus, if the appropriate level of care is available the individual can function at the highest level possible for him or her, and continue to make progress from one level to the next to the extent of the individual's capabilities. The following, selected from those definitions, seem to offer an adequate spectrum of levels of care.

A2. Long-Term Hospital is a level of care for persons with long-term illness or disability who require very high levels of nursing care on a continuing basis, i.e., virtually total care, beyond the capabilities of most nursing homes and/or patients who are prone to episodic medical emergencies requiring immediate physician intervention. All of the personnel required for hospital care are required as well as most of the equipment and department services, with the possible following exceptions: operating rooms, intensive care or coronary care units and an emergency department.

A3. a. Skilled Nursing Facility provides care for patients who require continuing 24-hour nursing care and/or supervision, and/or rehabilitation or teaching program. These patient needs frequently follow early discharge from an acute hospital setting and the patient needs cannot be met at home or in a lower level of institutional care.

b. A skilled nursing facility also provides care for patients with long-term chronic illness, whose primary need is relatively complete activities of daily living (ADL) care, skilled nursing care or supervision and medical supervision, when these care needs cannot be met at home or in a lower level of institutional care.

This level provides close medical supervision and 24-hour nursing care and/or supervision, as well as physical, occupational, speech and hearing therapies, social work, dietary, dental, podiatrist and pharmacist services, an activity program and electrocardiography. Services of a clinical laboratory and radiology must be available on the premises or by a satisfactory arrangement, as well as appropriate consultant services including psychiatry. A medical records system and patient charts are essential.

A4. Health Related Facility provides services to persons who because of physical, mental or social needs require institutional services in addition to board and lodging, but do not require the extent of services typically provided in a skilled nursing facility or higher level of care.

Persons who need care in and can in fact live best in a health related facility meet the following criteria:

a. They are ambulatory with or without mechanical aids.

b. They may need minimal to moderate help in one or two activities of daily living.

c. They may need help in taking medications.

> This level provides nursing supervision, recording of health information, dietary supervision, and minimal to moderate assistance with the activities of daily living. This level also provides for the supervision of mildly to moderately confused persons who are not a danger to themselves or others and who do not present major behavioral problems.
> Supervised Boarding Home provides care for individuals who are medically stable, ambulatory with or without mechanical assistance, not more than minimally confused, do not require constant supervision and are able to take their own medication. They may also provide therapeutic diets of unsophisticated nature and minimal assistance with bathing, dressing and toileting.
> Regarding medical care, an individual may require no more than regular ambulatory care; nursing supervision is provided by community health nurse; assistance with or supervision of activities of daily living is given by non-professional personnel rehabilitation is available on ambulatory basis or from a visiting therapist; recreational and socialization activities are provided.
> Home Health Agency (except hospital level home care) for individuals requiring only regular ambulatory care plus community health nursing; physical, occupational, speech therapy; and home health aide--supervised by a community health nurse.
> Non-Professional Support Services provides no nursing services. Assistance is provided for meals, shopping, laundry, etc. The individual must be medically stable, alert and ambulatory with or without mechanical assistance, and able to manage personal care.[5]

The availability and accessibility problem is a vital one. The problem of misplacement can be illustrated by the Monroe County bed surveys done in 1969-70 and 1975 which found that only 52.1% of skilled nursing patients and 23.4% of health related facility patients belonged at those levels of care in 1969-70;[6] the figures were 90.4% and 65.0% in 1975.[7] In fact, recent gerontological studies indicate that "as many as 40% of the elderly in nursing homes do not really need to be there."

Evaluation And Placement

A second important policy element, in addition to the availability and accessibility of a range of services, is an evaluation and placement process designed to evaluate the needs of individuals in relation to the range of services available. Evaluation and placement experiements have demonstrated the value of such a process. For example, an evaluation and placement project

was conducted in Monroe County, New York. Placements as a result of the evaluation process were 20% more accurate than placements described in studies conducted earlier in the same locality.[9] The evaluation process was also independently evaluated with similar results. Obviously, such procedures would be essential to effective utilization of the various levels of care cited above.

Two important points should be noted here regarding evaluation and placement. For the evaluation and placement process to work, it must include private pay patients as well as those supported by the government for a private pay patient able to select at will an unsuitable level of care would destroy the integrity of the system. Secondly, institutional admission policies could not be used to selectively screen out individuals.

Perhaps the necessity of such services is best summed up by the report of the Maryland Commission on Intergovernmental Cooperation which states that, "The importance of Geriatric Evaluation Services cannot be overemphasized in regard to its role in channeling at-risk individuals to the most appropriate alternative - emphasizing source of care. This function not only serves the individual best but also services to minimize the cost of the health delivery system."[10]

APPROPRIATE CARE: A CASE FOR FEDERAL CONTROL

Review of the Present Situation

Having discussed the future need for long-term care services, a policy framework, the need for a continuum of appropriate services, evaluation and placement procedures and level of care designations in the Introduction, one can review the present situation against that standard. Certainly, the combination of Medicaid and Medicare programs were developed to improve access of the needy and the elderly to health care services. Stephen Loebs, a Medicaid specialist, suggests that this intent has been met to a degree. He points out, however, that "political ideology and attitudes toward the poor"[11]

are a determinant in the range of services provided in the states, that there have been different degrees of response by the states to ensuring equitable access to services, and that this variation can be expected to continue if states retain control of the Medicaid program.[12] A comprehensive study of need for and availability of alternate care services (i.e. other than institutionalization) by the Western Wisconsin Health Planning Organization further supports the contention that a more equitable comprehensive plan is needed. This study concludes that "growth (of alternate care services) will be impeded until regulations and funding mechanisms are revised."[13] In the background report to that same study, John Hutchins, a health planner states that there is a "consensus that a readily available, full spectrum of care is needed for the elderly. There appear to be opportunities for improving the care and quality of life for the elderly and for substantial cost savings".[14]

Without question, the range of services currently provided under Medicaid, when compared to those discussed in the Introduction, is inadequate, the coverage is inequitable, and the rate of cost increase is unacceptable. Undoubtedly, demographic and health status factors will continue to seriously aggravate these circumstances in the foreseesble future. While many services are currently covered by Medicaid (inpatient hospital, outpatient care, laboratory and x-ray, skilled nursing, physician visits and home helalth care [but only certain services in the home similar to current coverage as above]). Eligibility for services varies from state to state in a number of ways as do the services covered with some states choosing to provide more than the minimum required for participation. The rate of cost increase is driven by general inflation in medical care costs, increasing eligibility as individual resources are consumed by general inflation and the cost of institutional health care, and increasing utilization as growing numbers of individuals reach the age where more and greatly intensified services are needed.

Federal Assumption of Greater Role in Long Term Care

There are two possible solutions to the Medicaid/Medicare problems. The first would be to improve the existing Medicaid (and Medicare) program in the context of the current funding formula. However, making more services available to a wider range of recipients with the federal and state governments sharing the increased expenditures under the current formula does not seem like an alternative with sufficient incentives to encourage change. Alternately, one might rearrange services in a more efficient manner within current expenditure constraints, but this seems unlikely to insure availability, access or equity.

The second option is for the federal government to assume a greater responsibility for the direction, control and financing of long-term health care as a means of achieving the standards set forth above. The hallmarks of such a proposal would include relieving the escalating cost burden of long-term health care on state and local governments, improving service through greater accessibility and availability of appropriate levels of care, long-term cost effectiveness and cost restraint, timely delivery of services and timely payment, better coordination of service delivery and better planning and evaluation through standardization and uniformity of data.

An important determinant in the choice of options is political feasibility. It is unlikely that the states would or could underwrite the costs of developing a full range of services. Revenue sources in the states are less elastic than those of the federal government and tax rate increases are subject to more local constituent pressure.

The goals of improving service and achieving long-term cost effectiveness and control could be achieved within the following parameters of a federal take-over of major responsibility for long-term care services:

- establishment of minimum federal guidelines regarding levels of care to be available and minimum services to be provided within those levels,
- emphasis on the development of less costly, more appropriate services, and establishment of requirements for planning and evaluation of care alternatives and for eligibility
- provision for continuing participation and local determination within the guidelines particularly in the areas of determining unique local needs and the construction of models or alternatives with a greater emphasis on accomplishing this at the regional and local level
- increasing the federal cost share, insuring that long-term care expenditures by state and local governments are stabilized for a period of five to ten years especially to the point that when they would resume participation in sharing cost increases, those increases would be at a rate consistent with general cost increases and furthermore would be predictable based on the experience of providing a full range of services for an eligible population over an extended period of time.

Federal Guidelines

Establishing minimum federal guidelines would be the initial step in insuring that appropriate services are available. One factor contributing to inappropriate placement of individuals in skilled nursing and health related facilities is the lack of suitable alternatives in the community. A 1970 study in Monroe County, New York found only 52.1% of the patients in nursing homes required that level of care and similarily only 26.1% in health related facilities.[15] A similar study of placement in 1975 showed improvement due to expansion of home care services and better evaluation and placement procedures, but the problem of inappropriate placement still abounds in Monroe County as well as the rest of the country. The establishment of federal guidelines would standardize and

assure minimum services within specified levels of care thus alleviating the problem, while containing costs.

Local Participation

Local participation and determination is essential because needs would vary from region to region in the country. It would be necessary, for example, to determine the quantity of a particular service needed in any single locality as well as the possible models for providing the service. Concentration of the elderly population, geographic characteristics and existing services would all have to be taken into account in developing needed services. Also paramount in terms of loca participation is the existence of state administrative and regulatory functions that would be absolutely essential components of operationalizing a greater federal role in financing long term care.

Federal Assumption of Cost

A major feature of a federal takeover is the federal assumption of the cost of financing long term care. First, most states would be given dramatic relief from rising long term health care expenditures. This would be accomplished by freezing the current contribution from a state or locality for a period of five to ten years while increasing the federal contribution both absolutely and as a percent of total expenditures in each state. In doing so, the total amount of money for long term care services is increased while the state and local contributions are stabilized. The increased amount is then used to develop new services, particularly those of less intensity and lower cost and to phase out services where excess exists. In doing so, the system could reach an equilibrium of 2020 that would be less costly than continuing our present course and provide more appropriate services.

As an example, the Maryland study illustrated the potential savings of $25,690,000 if long term care placements could be shifted to an optimal pattern.[16] While this certainly cannot be achieved immediately, it illustrates the possibilities for developing and appropriately using alternatives to our present patterns of care. In addition, the study estimated the costs for Fiscal Year 1977 for certain services should the federal government take 100% responsibility in Maryland under a national health insurance plan, assuming an optimal mixture of services. Total expenditures for nursing homes would be $71,150,000 compared to an estimated $100,000,000 under the current system; day care, home care and home health combined would be $1,240,000 less under a totally federal financing plan, even assuming all elderly to be eligible and that everyone who needs a service receives it.[17]

The factors used in the Maryland study to estimate the population in need of each level of care were first utilized in a study done in Monroe County, New York. The optimal placements are set forth below.

Percentage of Elderly Population Requiring Each Level of Care
According to Monroe County Study

0.8% - Acute Medical Care

0.1% - Subacute

0.1% - Psychiatric Inpatient Care

0.3% - Intensive Nursing Care

2.7% - Institutional

5.9% - Congregate Living

6.7% - Public Health Nursing Services at Home

83.4% - No Care Needed From Organized Service Agency[18]

Data to make similar estimates on a national level are not readily available. One could assume, conservately, that 5% of the nation's elderly are receiving intensive nursing or institutional care (compared to 3% above) and that this is equivalent to nursing home care for expenditure purposes. If so, national expenditures for nursing home care that totaled $7.1 billion in 1975[19] could theoretically be reduced to $4.26 billion. Even investing in the development of new services and allowing for an increase in the population requiring higher levels of care (i.e. less than the 2% differential calculated above), it seems clear that implementation of the federal takeover of long term care financing would result in a reduced rate of cost increase over a period of years, stabilized state and local expenditures and a continuum of care that more appropriately meets the needs of the elderly population.

There are some adverse consequences to such an approach. The first is a loss of some autonomy by state and local governments. This would be ameliorated to a certain degree by the serious consideration of the appropriate and necessary roles for all levels of government with the federal level setting necessary parameters to insure policy consistency while balancing this with the need for substantial local participation. The incentive of limited and stable expenditures should also reduce resistence to this change. Secondly, total expenditures would have to be increased in the initial years of the change to allow for expansion of services and entry of those currently excluded into the sphere of care.

In addition, many potential problems exist. One faces the policy question of where to draw the line between health services in such a program and other services such as housing and nutrition, a point recognized by the Maryland Commission, who simply reached the conclusion that, to begin with, " the health care system must take the responsibility for the health component of the problem."[20]

Another problem is the magnitude of the required change. It is difficult to estimate the time required to bring on line many new services in diverse areas across the country or to predict the problems to be surmounted in moving away from our current emphasis on institutional care. But the forty years from now until 2020 would offer ample opportunity to initiate and evaluate change, given the point, for example, that the useful life of a facility constructed today would be about forty years and those built yesterday somewhat less. In underscoring this dilemma, the Institute of Medicine suggests an initial restriction for total eligibilitiy to those 75 years and older as a way to get started.[21]

In addition, it should be clear that some services cannot be available in rural areas because they would be too costly on a small scale. However, a fuller range of services than is now available in most rural areas would have some of the same outcomes as already described--greater potential for functional independence for many individuals, less misplacement, and potentially, a reduction in overall costs. For example, day care and respite care services can be provided in existing facilities in order to reduce overhead cost for the program. When the additional cost of transportation is added in, the program can still be less expensive than institutionalization, particularly when transportation expenses can be shared with other community programs. There is also further potential to combine services. When individuals are gathered at a central location for a day care program, for example, they can receive other services such as nursing care and therapy that might otherwise have necessitated home care or eventual institutionalization.

Another possibility, in more isolated areas, is the placement of individuals with families that are willing to care for them--individuals who otherwise would have to be placed in an institution. While not all services could be provided in many rural areas, the addition of some services, as conditions allow, could benefit the individual and the community, and in many cases also be cost effective.

Conclusion

In summary, several problems are addressed by having a fully developed and readily accessible range of long term care services. First, the needs of those requiring long term care services would be more adequately met. No longer would individuals be placed in institutions when a less intensive level of care would suffice. In addition, the individual would have the encouragement and opportunity to improve--to go home from the institutions with the support of an appropriate array of home care services if necessary. They would be able to function at their highest possible level given their circumstances and limitations resulting in an enhanced quality of life for the individual.

Secondly, federal direction and control would insure at least a minimum level of equity and uniformity throughout the country. No longer would there be state to state variations in basic service patterns, service definitions or requirements for eligibility. The national approach would also necessarily be balanced by recognition of local and regional needs and resources so that programs would be appropriate and useful.

Finally, substantial progress can be achieved in dealing with the escalating costs of long term care. Given that we are, for the most part, paying for an excess of the highest and most costly level of care, substitution of lower and less costly modes of care combined with access for those individuals currently excluded from care until they require institutionalization (and thus postponing or eliminating institutionalization) will eventually result in an equilibrium in the system where most individuals are receiving the appropriate level of care. While the overall cost may continue to rise, and will certainly be substantial in developing new levels of care, it will reflect the rational allocation of services and will therefore be subject to more informed judgement regarding the value of the investment.

The policy statement of the Institute of Medicine accurately summarizes the theme developed in favor of a federal assumption of long term care financing.

The committee believes that a fundamental change in federal policy for care of the elderly is required to better meet the needs of functionally dependent old people and their families. The committee therefore recommends that:

> The federal government should reimburse for long-term care provided to the functionally dependent elderly. Long-term care should include both health and social services and should provide for choices between institutional and home-based care. Eligibility for federal reimbursement of long-term care should be based on a comprehensive assessment process.[22]

APPROPRIATE CARE: A CASE FOR STATE CONTROL

It is essential that the levels of care for Medicaid remain at the discretion of the states, planned and administered from a state or regional level, rather than be taken over by the Federal Government.

There are three basic reasons for this status quo position.

1. A federal takeover would cost far more money than is presently being spent, resulting in an even greater percentage of the Gross National Product given to medical care. Health expenditures have risen from $39 billion (5.9% of the GNP) in 1965 to $119 billion (8.3% of the GNP) in 1975.[23] At the present time, there is no segment of our society willing to see this percentage increase.

2. Political power and influence of the elderly will grow with an increasing demand for appropriate, locally based medical care and other non-medical services.

3. The states have a high ability to control the Medicaid programs both fiscally and through regulation of the system. The states have maintained the ability to provide licensure for other functions, and are far better prepared to maintain this function than federal agencies.

Four basic attitudes or sets of pressures determine the quality of health care in any given area: economic, legislative, scientific and humanistic.[24] These attitudes and values vary across the country. The United States is, by its nature, a fragmented society. People have come from different cultures and have chosen to live in different conditions. What is good for one area of the country is not necessarily good for all areas of the country. Health care reflects attitudes, culture, and customs of society. Since our society has prided itself on free enterprise and independence of the individual, it is unlikely that the public would choose to maintain a federal long-term care system for the poor. When administration and planning of levels of care is regional, consumers and providers are brought together. This provides for optional allocation of resources and a greater change of a balance between resources and human energies.

LEVELS OF CARE

There are two major conditions affecting the choice of care levels at the present time:

1. Movement of elderly patients causes major psychological trauma and, in many cases, might prevent cure from occuring.

2. The attitude of long-term care practitioners often favors treatment of symptoms over rehabilitation.

A system where these two conditions are seriously addressed will become a more efficient system. If the overall scheme of care begins at home, or locally, a basic philosophy of prevention and rehabilitiation is possible.

Prevention stressed at the local level may reduce many very expensive entrances into the Medicaid system. Instead of entering a hospital for primary diagnosis of a problem, a patient could be seen at a clinic or some less comp-

rehensive center and referred to an appropriate level of care immediately. The existence of varied levels of care would alleviate one major problem of Medicaid which is the placement of patients in overly costly hospital beds for long periods of time when other levels of care are not readily available. Another major problem, the trauma inflicted upon the ill elderly when the movement from one facility to another occurs could also be solved by housing many levels of care within the same facility. In fact, hospitals are already experimenting with methods of treating the less seriously ill patient. Mothers with new babies are encouraged to care for their newborns themselves, and to become mobile as early as possible; post-operative patients who only need occasional nursing are taking more and more responsibility for their own care in less intensive areas of the hospital. If a patient could switch to a less costly status within the same institution, both the problem of appropriate placement and the problem of movement could be addressed. A patient could be within reach of nursing care and laboratory and testing facilities during those times when the services were necessary, and then could have these costly services reduced as improvement occurs. Such cooperation among hospital administrators, physicians, and nursing home owners would be challenging and would require great cooperation. Such cooperation is more likely at a local level.

States should, in the future, mandate the following three types of services and movement between them should be made feasible:

1. Home Care. If impairment is not severe and home rehabilitation is possible, home visits by physicians' assistants, nurse practitioners, occupational and physical therapists would encourage rehabilitation and could be provided at as low or lower cost than hospital or nursing home care. Prevention of further trauma could be emphasized.

2. Skilled Nursing Facility. This is the one area which could benefit the most from a swing in hospital beds from acute care. So often the bottle

neck for Medicaid patients occurs when patients are left waiting in a hospital for beds to become available in nursing homes. Local and state control of the number of beds available in each facility could help to reduce this problem. Also, when rehabilitation is heavily stressed, there should be increased movement out of the SNF to a lower level of care.

3. Custodial Care. Though it is essential to provide basic care for those patients who appear to need permanent caring, this level also should stress rehabilitation to the level where it is possible.

Given the political future for the elderly and the increase expected by 2020 in the numbers of people over 65, the communities of the future should have the desires and skills to make the care for elderly people more humane. There will be more lobbying groups and more willingness to provide non-medical services for older people.[25] Thus, actual levels of care provided by Medicaid could and should be limited to the above areas.

Since transfers from one area of care to another are fraught with communication problems, counseling, placement, and referral will play an increasingly important role in 2020.

FRAMEWORK FOR LEVELS OF CARE

There are two basic means for controlling quality and quantity of long-term care: regulation and reimbursement. To be effective, these practices need to be timely and enforced. The closer the source of care is to the administration, the better the administration will be.[26]

As suggested earlier, a major problem of Medicaid has been inappropriate placement, resulting in higher costs and unsuitable care. In a New Jersey study it was found that 35% of intermediate care level individuals could be discharged to a more appropriate setting.[27] Here, intermediate care was defined as the

nursing home. Senility problems were more likely to be appropriately placed in a full or intermediate care setting [custodial]. Musculo-skeletal problems were often more appropriately placed in home or day care settings. The study concluded that more than 1,700 persons could be placed at a more appropriate level of care, and, in some cases, at a lower level, if that care were available. Care which meets the needs of the individual is more likely to be made available at a local level of influence and control.

There are many possible frameworks for state funded programs. Any framework should depend upon a tight cooperation among three categories of agencies. There should be an organization to evaluate and place individuals at appropriate levels of care. Screening and evaluation should include a complete medical and psychological workup with interviews with the client and all members of the client's family. The goal of such screening would be to find the most medically and socially fitting placement at the lowest level of cost. If this service is functioning well, state differences in covering different services could be justified. This sytem would also serve those who could afford to pay as well as Medicaid patients. One example of such a program is ACCESS, a service offered by Monroe County Long Term Care, Rochester, New York.

Working closely with the placement and screening agency would be a number of organizations providing advocacy for people needing long-term care. This agency or agencies, would also provide a setting for political education and support services for all elderly people. One example of such an agency is the Regional Council on Aging in Rochester, New York, which includes the ombudsperson program for nursing home residents and an organization called Citizen Leaders for Action in Rochester (CLAR), a political action group, which provides information and volunteer services for the aging.

The third necessary component for a state administered program is a planning element, such as the Regional Health Systems Agencies, set up throughout the

country in 1974. Presently, these agencies are in the position of being able to evaluate programs and plan new ones through each state.

All three of these processes depend upon tight community cooperation. If this cooperation were carefully controlled, financing and licensing could be handled by the State. In this way, health care needs would match health care services and health care dollars.

AGAINST A FEDERAL TAKEOVER

Several reasons have been given for changing our Medicaid system to a Federal system. There is a suggestion that a federal takeover would increase the available range of services and provide an appropriate mix of services. In order to avoid gaps in service and an enormous waste of dollars, these items could only be facilitated on a regional level.

Another suggestion is that a federal takeover would relieve financial burdens on the states and localities, thereby stemming cost escalation. The burdens should be placed as well as possible where they belong: on the family and community. When there is no direct contact between money and services, it is easy to forget the function of budgeting.

There should certainly be a policy framework for establishing levels of care, but it should be done on a state level with local or regional input. It is easier to be aware of the interrelationships and the need for community co-operation from a local and community level.

Evaluation and placement are obviously a crucial element in establishing levels of care which are most appropriate. This is a policy which would be appropriately mandated at a state level. Eligibility for services will vary according to the needs of the community and the levels of care available.

Improving existing services and working within the regional system is an attempt to stay within the simplest framework possible. To go to the more complex system of a federal takeover before mastering the more simple structures would mean financial and bureaucratic disaster. There would be an increasing possibility that Medicaid patients would fall through the spaces between services. Also, a more complex federal network would remove the consumer—whether the consumer is the patient or the taxpayer— from the provider, inviting waste of human and financial resources. Cost controls work best when they are linked directly to services.

An argument for federal takeover is that it is unlikely that states could or would underwrite the costs of developing a full range of services. The states should not need to develop a full range of services. If anything, the states should act as a control for unnecessary services.

Increasing federal cost share is often thought of as a way to relieve financial burdens for the consumers, or taxpayers. It is ridiculous to think that the taxpayer does not end up paying more. The money still comes from the same source. It is only disguised in the process.

A loss of autonomy by state and local governments would place additional hardships upon the Federalist system, which thrives upon autonomy of state and locality and intergovernmental cooperation.

When levels of care are mentioned, it is difficult to separate the conditions which should exist within a community to promote human dignity and those services so medically necessary as to be provided by the government when they are not affordable. When there are many services and levels of care provided by the government, communities find less incentive to improve the state of its members.

CONCLUSION

The problem of appropriate care levels for long-term care patients may be best solved by having the administration and control of care as close to the consumer as possible. Though federal direction and control would insure a level of equity and uniformity throughout the country, that level would prove to be inappropriate for large segments of our fragmented society. We need to feel responsibility and control of our lives in order to avoid apathy.

Finally, the cost control for long-term care must remain close to those who must pay the bills and those who receive the services. These are the only groups, combined with professional advisors, which can make decisions upon levels of care within Medicaid.

FOOTNOTES

[1]The Elderly Population: Estimates by County 1976, U.S. Department of Health, Education and Welfare, Office of Human Development Services - Administration on Aging, DHEW, Publication No. (OHOS) 78-20248, p. 130.

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