THE CENTURY FOUNDATION
Issue Brief

FACING THE PROBLEMS OF PROVIDING LONG-TERM CARE FOR THE OLDEST OLD

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INTRODUCTION

As the first members of that huge generation known as the baby boomers begin to reach retirement, they are clearly more active and in better health than were earlier generations reaching that milestone.[1] The boomers are looking forward to some two decades or more of what they believe will be an active, enjoyable third stage of life, given increases in longevity. What few of them have spent time contemplating, however, are the long-term problems that those extra years can bring: Will they be able to afford their new longevity? Will they remain healthy until the day they die? Who will care for them when they no longer can care for themselves?

Although the issue for all of us is the potential impact that this growing segment of the population will have, particularly on our national economy, this brief will focus on the problems specific to those who live the longest—the oldest old[2]—looking in particular at (1) their special needs, (2) the costs of the long-term care necessary to meet those needs, and (3) the challenge of finding enough health care workers to provide that care.

I. DEMOGRAPHIC REALITIES

The oldest old, that is, people aged 85 or older, are currently the fastest growing segment of the population. By 2010, the population aged 20 to 64 (that is, those who make up the potential workforce) will comprise 60 percent of the total population, while the oldest old will make up only 2 percent; in 2030, those numbers change to 54.2 percent and 2.6, respectively; and by 2050, the available workforce makes up only 53.4 percent of the population, while the oldest old are projected to comprise 5 percent of the population. (See Table 1, page 2.) The other demographic reality is that Medicare spending rises as beneficiaries age. Looking at the figures for 2003 reveals the inevitable growth in spending. (See Table 2, page 2.)

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Table 1. Projected Population of the United States, by Age, 2000 to 2050						
	Projected Percent of Total Population					
Age	2000	2010	2020	2030	2040	2050
0–4	6.8	6.9	6.8	6.7	6.7	6.7
5–19	21.7	20.0	19.6	19.5	19.2	19.3
20–44	36.9	33.8	32.3	31.6	31.0	31.2
45–64	22.1	26.2	24.9	22.6	22.6	22.2
65–84	10.9	11.0	14.1	17.0	16.5	15.7
85+	1.5	2.0	2.2	2.6	3.9	5.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: "U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin," U.S. Census Bureau, 2004, available online at http://www.census.gov/ipc/www/usinterimproj/natprojtab02a.xls.

Table 2. Medicare Spending Rises as Beneficiaries Age (2003)		
Age	Percent of Enrollees	Percent of Spending
Under 65	14	14
65–74	43	32
75–84	31	37
85+	12	15

Source: Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare Program*, June 2006, available online at www.medpac.gov/publications/congressional_reports/Jun06DataBookSec2.pdf.

II. The Special Needs of the Oldest Old

While senior citizens—in particular the group known as the young old (those from age 65 to 75) but also the old (age 75 to 85)—as a whole are in better health than their counterparts in earlier generations, the oldest old present a dramatically different picture.

- According to a 2002 study by the Kaiser Family Foundation, 31 percent of all Medicare beneficiaries (that number includes the disabled) have problems performing activities of daily living (ADLs), a term that refers to eating, bathing, dressing, using the toilet, and transferring, say, from bed to chair or wheelchair to toilet. Of that group, 25 percent were between age 65 and 84, while 51 percent were over age 85. When it comes to what are known as instrumental activities of daily living (IADLs, that is, activities related to independent living, such as preparing meals, managing finances, shopping, doing light or

heavy housework, or using a telephone), 45 percent of those over age 85 had one or more such problems, while only 26 percent of those aged 65 to 74 did. When a majority of these activities are beyond an individual's capabilities, the person needs help in order to live outside an institution.[3]

- The September 2005 report of the President's Council on Bioethics estimates that "roughly half the people over 85 will suffer major cognitive impairment or dementia as part of their final phase of life. At present, according to the Alzheimer's Association, an estimated 4.5 million Americans have Alzheimer's disease; by 2050, the number of Americans with Alzheimer's disease is estimated to range between 11 million and 16 million—unless a cure or prevention can be found."[4]

- When an individual can no longer manage on his or her own and cannot afford home health care, which usually is paid for out-of-pocket, a nursing home is often the only solution. Approximately 1.6 million people aged 65 and older live in nursing homes in the United States, and the oldest old are the greatest users of this service. Fifteen percent of those residing in nursing homes in 2005 were aged 65 to 74, while 37 percent were aged 75 to 84, and 45 percent were over 85.[5] Most of those who need nursing home care go to one of the 17,000 Medicare and Medicaid certified nursing homes in the United States. These homes vary in type and purpose, ranging from those that provide many levels of care to those that specialize in offering a temporary place of care and rehabilitation for someone who has just been released from the hospital after a serious illness, to those that serve as a long-term permanent residence for someone who no longer can live on his or her own and has no one to live with and cannot afford or manage with home health care, to those that provide only end-of-life care (hospice care).

- Low-income individuals tend to have had more health problems, such as diabetes, throughout their lives, and as they grow older, they tend to have a greater need for long-term care than do those with higher incomes. At the same time, the older the person, the poorer he or she is, usually as a result of decreases in assets, pensions, and earnings. In 2005, the median income of individuals age 65 to 69 was $18,249, declining to $14,857 for those age 70 to 79, and falling to $13,999 for those over 80.[6] According to an earlier report by the Kaiser Family Foundation, "Nearly two of five (39%) of those age 85 or older live on incomes at or below the poverty line, a rate 50 percent higher than the rate for those aged 65 to 84 (22%). Women are disproportionately represented among Medicare's oldest old and Medicare's poor. Two-thirds (68%) of poor Medicare beneficiaries are women."[7]

- Specific information about the health needs of the oldest old is often unavailable, and there is already a severe shortage of people with geriatric training. Atul Gawande, assistant professor of surgery at Harvard Medical School, says that only three hundred doctors are likely to complete geriatric training this year, and 97 percent of medical students do not take a single course in geriatrics.[8] When it comes to medication, since drug trials rarely include the oldest old, the effects of medications on this group, such as the different rate at which drugs are metabolized as one grows older, often are unknown. Moreover, the older one gets, the more medications one is likely to be taking and the greater the danger of interactions between them causing problems.[9] In addition, treatments considered normal for younger patients, may, in the case of the oldest old, need to be modified. For example, according to a study in the *Journal of the American Geriatrics Society*, "there remains considerable uncertainty

regarding target blood pressure (BP) in the very old, and concerns exist that excessive lowering of BP in this age group may result in falls, strokes, or cognitive problems, including depressive symptoms, that themselves may result in additional morbidity and mortality."[10]

III. The Costs of Long-Term Care

Providing care for the growing population of oldest old will be costly for government, business, and individuals.

- A RAND white paper reports that the "U.S. government forecasts that the cost of long-term care will reach $379 billion, in current dollar values, by 2050."[11] Moreover, according to testimony by Karen Ignagni of America's Health Insurance Plans, the "20 percent of all Medicare beneficiaries—chronically ill patients with five or more medical conditions—accounted for more than two-thirds of the Medicare program's costs in 2004."[12]

- When it comes to long-term care for the oldest old, much of the cost involved is met by Medicaid because so many of that group are in poverty. Leif Wellington Haase reported in a Century Foundation essay that "although seniors and the disabled only make up about one quarter of the Medicaid population, they account for about 7 in every 10 dollars in spending. Most of this spending goes toward long-term care, assistance, and services for individuals who are unable to perform basic activities."[13] This reliance on Medicaid imposes a financial burden on state governments, which pay roughly half of the costs of Medicaid—an amount that currently accounts for about 20 percent of their budgets. Many state and local governments are warning that the coming growth in the number of seniors will make it impossible for them to cover such payments.

- When it comes to nursing homes, the Center for Community Economic Development at the University of Wisconsin-Extension reports that while such facilities "serve only about 5 percent of the elderly at any one point in time, they consume the largest proportion of public dollars spent on the elderly."[14] The sources of payments for the approximately 1.6 million people receiving nursing home care are diverse, with a major proportion coming from public funds. (See Table 3, page 5.)

- The costs of long-term home care from licensed agencies—that is, those who provide bonded, insured, and certified aides—averaged $19 an hour nationwide in 2005, "$1, or 5.5% more than in 2004."[15] Thus, around-the-clock care from aides hired from agencies can cost more than $150,000 a year, and such care is not covered by government assistance unless patients are poor or fresh from a hospital stay. As a result, in order to obtain needed assistance many turn to the so-called gray market to find help—caregivers who are not trained, screened, or supervised, but who are found through personal recommendation and are much less costly, especially since the rates they charge do not include agency fees.

- Although many families try to provide some of the care needed themselves, doing so is often a problem in our mobile society, where family members often live at long distances from one another. Even when distance is not a problem, the costs involved when a family member provides total care may be substantial, since today most families depend on two incomes. In addition, large numbers of workers assuming caretaking responsibilities can have an adverse effect on business. There are costs involved in finding replacements for those

leaving the paid workforce to care for aged family members since they are usually older, more experienced, and skilled workers. According to *Workforce Week,* an "estimated 9 percent of the caregivers who were employed left the workplace as a result of their caregiving responsibilities; 3 percent took early retirement and 6 percent left work entirely. An additional 10 percent of the employed caregivers reduced their hours from full time to part time." The report also noted impacts on productivity as a result of workers with caretaking responsibilities: it estimated that lost productivity alone, already more than $33 billion per year, will rise as the boomers age and have to take responsibility for providing or supervising care for their parents.[16]

Table 3. Sources of Payment for Nursing Home Care, 2004	
Source	Amount (in billions of dollars)
Out-of-pocket	31.9
Third party	83.3
Private health insurance	9.0
Other private funds	4.2
Public	70.0
Federal	48.4
State and local	21.6
Medicare (from federal funds)	16.0
Medicaid (from federal, state, local funds)	51.1

Source: U.S. Census Bureau, *The 2007 Statistical Abstract: The National Data Book*, Table 127, available online at www.census.gov/prod/2006pubs/07statab/health.pdf.

- Some 8 million people have bought long-term-care insurance to protect themselves. The details of the coverage offered and the conditions attached to it are often confusing, and the costs are substantial, especially for the elderly at the bottom of the income scale. (See Table 4, page 6.) The *Journal of Financial Planning* reports that "many upper-middle-income individuals (around $60,000 to $100,000 a year) presumably could afford a $1,000 to $2,000 annual LTC insurance premium, . . . most middle-income individuals ($30,000 to $40,000) may not be able to afford those premiums. . . . Lower-income individuals (say around $20,000) could seldom afford LTC insurance premiums."[17]

Table 4. Average Annual Premiums, 2002 ($150 Daily Benefit; 90-Day Elimination Period; 4 Years of Coverage)		
Age	Base Plan	With 5% compounded Inflation Protection
50	$564	$1,134
65	$1,337	$2,346
79	$5,330	$7,572

Source: Enid Kassner, "Long-Term Care Insurance Fact Sheet,"AARP Public Policy Institute, September 2004, available online at www.aarp.org/research/longtermcare/insurance/fs7r_ltc.html.

- Unfortunately, in addition to premium costs, many people have discovered that such insurance is not the safety net they thought it would be, given the actions of some of the companies selling these policies. According to the *New York Times*, "some long-term-care insurers have developed procedures that make it difficult—if not impossible—for policyholders to get paid. . . . In California alone, nearly one in every four long-term-care claims was denied in 2005." The article goes on to note that "few of the cases or complaints filed against Conseco, Bankers Life, Penn Treaty or other insurers have received much attention, in part because many lawsuits filed against long-term-care insurers have been settled with the requirement that depositions, documents and settlement terms be kept confidential" and that "despite the complaints against long-term-care insurers, few states have conducted meaningful investigations."[18]

IV. The Caregivers

Another critical issue will be ensuring that there are enough caregivers, both in nursing homes and for home health care, to meet the increasing need for them as the population of oldest old increases. According to Department of Health and Human Services estimates, the number of people who will be needed to care for the elderly in the future will reach 2.7 million by 2010 and range from 5.7 to 6.5 million by 2050.[19]

- Although many of today's oldest old are able to depend on their families for care because they had a large number of children (the baby boomers), the boomers themselves are not likely to enjoy the same luxury: "20 percent of baby boomers have no children, and 25 percent have only one child."[20] In fact, according to a report by the President's Council on Bioethics, "by 2020, 1.2 million people aged 65 or older will have no living children, siblings, or spouse."[21] If family members are not there to provide care, home health care aides and nursing homes will be needed to replace them.

- For many elderly, going to a nursing home is considered a last resort, because although there are homes that offer good care, many, especially those with high rates of Medicaid patients, do not.[22] In testimony before Congress, Daniel R. Levinson, inspector general at the U.S. Department of Health and Human Services, said that "some nursing home care problems are so serious that they constitute 'failure of care'. . . . These cases often involve allegations

of widespread or systemic problems such as excessive falls, medication errors, an undue number of residents with facility-acquired pressure ulcers, and chronic staff shortages."[23] In a spring 2007 report evaluating the problems found in nursing homes, the Centers for Medicare and Medicaid Services (CMS), the federal agency that manages these two public health care programs, concluded that "despite changes in federal enforcement policy, almost half of the homes . . . with prior serious quality problems continued to cycle in and out of compliance, continuing to harm residents. These homes corrected deficiencies only temporarily."[24]

- The problems with the quality of care available at nursing homes are likely to increase, especially when it comes staffing issues, because of current trends in nursing:
    - There currently is a nationwide shortage of registered nurses, and this gap is projected to increase. (See Table 5.) One of the factors that will exacerbate the shortage in the near future is the number of trained nurses who are boomers and soon will reach retirement age; another is a lack of capacity at nursing schools. Even though the "National League for Nursing reported a 16 percent increase in applicants to bachelor's degree nursing programs and a 28 percent increase in applicants to associate degree programs" in 2005, that same year nursing schools had to turn away "almost 150,000 qualified applicants—up 18 percent over the previous year." The problem is that nursing schools do not have enough faculty because the demand for nurses has driven salaries up so that nurses with advanced degrees—who would normally make up nursing school faculties—choose to work in hospitals where they earn far more than they would teaching.[25]

Table 5. Projected U.S. Full-Time Employed Registered Nurse Supply, Demand, and Shortages

	2000	2005	2010	2015	2020
Supply	1,890,700	1,942,500	1,941,200	1,886,100	1,808,000
Demand	2,001,500	2,161,300	2,347,000	2,569,800	2,824,900
Shortage	(110,800)	(218,800)	(405,800)	(683,700)	(1,016,900)

Source: "What Is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses?" U.S. Department of Health and Human Services, September 2004, available online at http://bhpr.hrsa.gov/healthworkforce/reports/nursing/rnbehindprojections/4.htm.

- According to the *Online Journal of Issues in Nursing,* there are two other important issues when it comes to registered nurses, even when they are willing to work in nursing homes. First, the same lack of gerontological training noted in the case of physicians is true of nurses: "fewer than 25% of baccalaureate nursing programs include a course in gerontological nursing," and second, at this point in time, while only 12.3 percent of registered nurses are from ethnically diverse groups, about 33 percent of the general population is ethnically diverse; moreover, the situation is likely to worsen over time, for while "in 2000, 16% of older adults in the US were members of ethnic groups, . . . by 2050, the proportion is expected to increase to 36%."[26]

- When it comes to home health care aides, the *New York Times* warns that the "demand for home care aides throughout the industry is expected to outstrip supply. The Bureau of Labor Statistics counted 663,280 such aides in 2005, up from 577,530 in 1999, a tally that does not include gray-market workers."[27] And despite that increase there is still a shortage, one that is only going to worsen:
    - The Census Bureau reports that there is a "stagnant number of women with little education, ages 25 to 54, the traditional labor pool for this occupation."[28] That is true of the American workforce, but not true of many women from abroad who are eager to work in this country at that kind of job. According to the *Wall Street Journal,* "immigrants, whether legal or undocumented, make up a disproportionate share of those who care for the elderly—and the need for such workers is set to explode in the coming years. . . . One Census Bureau survey counted 850,000 low-skilled home-care workers in the country, 254,000 of them born abroad—and that number doesn't count many undocumented immigrants caring for people privately."[29] But this solution to the current shortage of aides is being fought vigorously by those who would seal the borders and even deport all those here illegally, exacerbating the current shortage of such aides.
    - Efforts to improve conditions for these workers are under way, but they are encountering resistance. For example, according to the *New York Times*, a case is coming before the Supreme Court in 2007 aimed at "challenging Labor Department regulations that say home care attendants, who number 1.4 million, are not covered by federal minimum-wage and overtime laws." The Service Employees International Union (the nation's largest health care union) is backing the plaintiff's effort because "a victory for her could mean larger paychecks for hundreds of thousands of home care aides, many of whom live in poverty," and the AARP is planning to file a brief in support on the grounds that the "increased pay that would result from requiring overtime coverage would reduce turnover among home care aides and help prevent a shortage." The resistance to these efforts is coming from those who would end up having to meet the increased costs that would result. In the case just noted, the federal government and New York City are arguing that a victory by the plaintiff "could force the city, state and federal governments, which all finance home care through Medicaid, to pay $250 million more a year to the 60,000 home attendants who work in the city."[30]

V. The Way Out

The following are some recommendations for changes that can take us in the right direction.

Addressing Special Needs

- **Devote more federal and state funds to educating people about the need for lifetime preventive care, making certain that special efforts are aimed at low-income individuals, and provide funds to ensure such care is available.** There is too little focus on preventive care and not enough testing for the presence of diseases before they manifest themselves as serious problems. In the case of diabetes, for example, studies have shown that one-third of adults with the disease do not know they have it.[31] Education about the importance of prevention and testing is necessary because it has become evident that, even when people are aware that testing and care services are available, they often do not take

advantage of them. For example, the preventive physical examination provided by Medicare in the first six months after a person enrolls in Medicare Part B, typically at age 65, is underutilized, even though there are doctors who take assignment and accept the Medicare-approved amount as payment in full.

- **Increase federal funding for research on Alzheimer's disease.** At the moment, most of the funding for research into finding treatments for, and perhaps a method of preventing, this devastating disease has come from a group of scientists, philanthropists, and maverick entrepreneurs who have "come together and put forth new scientific approaches and new funding sources to push the field forward." These efforts are beginning to bear fruit, and today there are a number of drugs in clinical trials that show promise. Yet, although Alzheimer's is the "third most expensive illness after heart disease and cancer . . . the federal government budgeted only $645 million for Alzheimer's research for 2007, $7 million less than the prior year."[32]

- **Provide greater oversight of nursing homes and strict penalties for serious failures of care.** After reviewing conditions in nursing homes and the problems of ensuring compliance by underperforming homes, the Government Accountability Office made a series of recommendations, including putting in place an "immediate sanctions policy to help ensure that homes that repeatedly harm residents or place them in immediate jeopardy do not escape immediate sanctions," expanding a "program of enhanced enforcement for homes with a history of noncompliance," and improving the "effectiveness of the agency's data systems used for enforcement." However, it warned that following these recommendations would not only require additional resources but also pose the danger that such actions might force many homes to close.[33] The problem is that so long as the number of people needing nursing homes continues to rise, exacerbating the current shortage of homes and staff to provide adequate care, penalties that force homes to close could worsen the situation. If in addition to imposing oversight, we also took action aimed at helping people remain at home for as long as possible, then it would make sense to allow penalties and market forces drive the worse performers out-of-business.

- **Provide alternatives to nursing home care for the poor.** Many people in nursing homes who have spent months in hospital settings before being placed in those homes find themselves without a place to go when the time comes when they could, with some assistance, live on their own again. Moreover, for such individuals, there is no way they could afford assistance if they did have a home to return to. At this time, Medicare pays nothing for assisted living, and Medicaid pays very little, leaving individuals to pay virtually all expenses involved out-of-pocket. Since more than half of those over eighty-five have incomes below $15,000, alternatives to staying in nursing homes will require programs designed to pay some or all of those costs, as discussed in the section on funding below.

- **Establish programs to train primary-care doctors, nurse practitioners, and others who provide nursing care in geriatrics.** The small number of physicians currently in practice as gerontologists should be encouraged to devote themselves to attracting and training primary care doctors in gerontology through programs that will pay them enough to allow them to devote their energies to such efforts. In addition, more efforts should be made to train and certify nurse practitioners; these are registered nurses, usually with master's degrees, who meet stringent certification requirements that allow them to work in

collaboration with physicians. Every state allows nurse practitioners to write prescriptions, and sixteen states even allow them to practice independently. They offer a cost effective alternative to doctors, and if they specialized in geriatric care, given their ability to prescribe medications, they would be invaluable as providers of care for the homebound, which would help reduce the need for nursing home placement.[34] Moreover, if all nurses were trained to recognize and alert physicians and families to specific problems in the elderly, such as depression, malnutrition, isolation, and danger of falling, care for such patients would improve.[35]

- **Ensure that drug trials include the elderly; that possible interactions between drugs used by the elderly are reported, studied, and information about them made available; and that information about patients' medication is collected in a central database so physicians and pharmacists can check for potential dangerous interactions.** For years, those over the age of 65 were excluded from virtually all clinical trials. That is finally beginning to change: today, nearly 20 percent of participants in trials are over 65. Moreover, in a promising development, "more than half of the drugs now being evaluated in clinical trials are aimed at treating conditions associated with aging."[36] Establishing databases to collect information on all prescriptions filled and giving physicians access to those databases would solve many of the problems of overmedication of the elderly. (More than half the states already have such databases in place for prescriptions for controlled substances. These existing databases may offer a starting point for the collection of broader information.)

Funding Health Care

- **Cover long-term care through a social insurance mechanism like Medicare.** In testimony before Congress, Joshua Weiner reported that "according to the Congressional Budget Office (2004), total (public and private) long-term care expenditures on older people are projected to increase from 1.3 percent of the Gross Domestic Product (GDP) in 2000 to 1.5 to 2.0 percent of GDP in 2040."[37] The Medicare program is an especially good model to follow in creating a method of paying for long-term care, especially given its low administrative costs. Before adopting such a plan, however, comparative studies should be made of nations that already have such social insurance plans in place. Over the past decade, countries such as Germany and Japan, the latter in the midst of a recession and graying faster than we are in this nation, have implemented universal long-term care. Germany enacted a universal-coverage social insurance program for long-term care in 1994 that was aimed at replacing its means-tested system. A study of the program reports that it "has achieved many of its stated policy goals: shifting the financial burden of long-term care off the states and municipalities; expanding home and community-based services; lessening dependence on means-tested welfare; and increasing support of informal caregivers. Many of these goals were reached without exploding caseloads or uncontrolled expenditures."[38] In the case of Japan, the original programs have been revised over time, which may make it a good place to study the kinds of problems that can develop with various programs.[39]

- **Encourage the use of, and payments for, alternatives to nursing home placement.** Home and community-based services (HCBS) make up some 36 percent of Medicaid spending. These services, which include assistance with daily activities ranging from personal care, transportation, shopping, and adult day services, can be used in a number of settings,

including one's own home, assisted living facilities, supported housing, and foster homes. Unfortunately, these services are provided through the states and are often are of limited availability; moreover, eligible individuals (that is, people at risk of having to be placed in a nursing home without them) are not entitled to the services, but receive them only as places for new clients open up. Another problem is that finding information about these services can be especially difficult when the elderly relocate or a relative who lives in a different state is trying to make arrangements because the plans vary from state to state. For example, only twenty-seven states had personal care services programs, which are an optional Medicaid benefit, in 2004.[40] State education programs aimed at providing clear explanations of what alternatives to nursing homes are available would be useful adjuncts to the programs themselves.

The major issue for payers is, Do these alternatives reduce costs? According to the Department of Health and Human Services, finding the answer is difficult because

> [while] the average private pay cost for a year of nursing home care is now estimated to be $46,000. . . Medicaid does not pay private pay rates. . . . Average Medicaid rates are at least 25 percent and perhaps as much as 33 percent lower than private pay rates. In addition, most Medicaid-covered nursing home residents have some personal income from Social Security, private pensions, and other sources that must be applied toward the cost of nursing home care. Typically, such private income covers from one-quarter to one-third of a Medicaid nursing home resident's monthly bill. [As a result,] per capita Medicaid spending on nursing home care averaged $2,426 per month in 1995. This means that if the average state spent more than this amount per month on home and community-based services for an individual client, they would likely to be spending more than they would have spent had that same individual entered a nursing home. Requiring clients to apply their private income toward the costs of home and community-based services—as would be required in the nursing home—is impractical because when an individual resides in the community all or most of those funds are needed to cover basic living expenses.[41]

As a result, most analyses conclude that these alternates to nursing homes do not offer significant savings, but such alternatives should be made available because they are greatly preferred by the elderly and because they would reduce the need for nursing homes, forcing homes to improve in order to compete for clients.

- **Expand the available tax credit for family caregivers or pass legislation providing direct cash payments to family members who provide such care, and encourage more long-term care insurers to offer the option of having payments for care made to a family member or friend who provides care.** The availability of a credit or payment is most important to low-income families because they often cannot forego a salary to provide full-time care and the jobs they hold usually do not offer the kind of flexibility that would allow them to mix caretaking and working. As a result, the person who they would otherwise care for will, in all likelihood, end up on a nursing home, with the bill paid for through Medicaid. Compensation for such family caretakers, whether through credits or cash

payments, should be kept low enough that the cost to taxpayers will be less than paying for nursing home placement. Moreover, making it possible for family members to provide care for the oldest old will ease the shortage of home health aides.

- **Encourage businesses to offer various programs aimed at easing the caregiving problem for workers, which would aid in retention, decrease absenteeism, and improve the productivity of workers carrying the burden.** Some companies, such as IBM, have instituted corporate elder care programs similar to child care programs, including flexible work arrangements and paid family leave. In addition, some companies are providing management services that do research for workers about available adult day care services, agencies that provide aides, nursing homes, and financing programs; some go further, providing back-up care services and medical decision support resources.

- **Expand the use of private long-term care insurance by increasing the kinds of protections they offer.** Citizens of some states have an alternative to buying on the open market. Some states have Long-Term Care Partnership programs that offer policies that allow buyers to protect a designated amount of assets in return for their purchase. For example, the New York State partnership program offers Dollar for Dollar Asset Protection policies that establish asset protection based on the amount of benefits paid from the policy when policyholders apply for Medicaid Extended Coverage, while New York's Total Asset Protection policies allow policyholders to protect all of their assets when they apply for Medicaid Extended Coverage. Again, such policies are too costly for many, but they are a good deal for those who can afford the premiums.[42]

- **Strengthen state oversight of the companies providing long-term care insurance.** When it comes to private long-term care insurance, stricter state oversight of providers is critical, especially since there is no federal scrutiny of the industry. The public must put pressure on their state insurance commissioners to investigate complaints, including by bringing those complaints to the attention of the media.

Ensuring the Availability of Caregivers

- **Create a civilian health service corps that will train people to provide basic home health care in return for funds for vocational training or community college education after a given term of service is completed.** Although the people who serve in the health corps will not have to commit to pursue a health care career, the time they spend in the corps will ease the shortage of home health care workers. Moreover, payments for the services they provide and the funds to pay for their future tuition costs can be set at a level that replaces the funds that would otherwise have to be met by Medicaid. Any costs over that will be more than made up for by the public good that accrues from a more educated workforce.

- **Provide forgiveness for loans taken out to cover college tuition for nurses who work for a certain mandated time in nursing homes.** Senator Robert Menendez of New Jersey has already proposed expanding the College Access and Affordability Act, which is currently available to certain teachers, to other public service employees, including nurses.

- **Provide funding to help nursing schools expand to train more nurses, develop courses in the area of gerontology, and provide training in diversity.** A shortage of

faculty is the main reason nursing schools have not been able to expand. Congress has addressed the problem in the Nurse Reinvestment Act, which was passed in 2002 and includes a government loan repayment program for nurses that provides scholarships in exchange for at least two years of service in a health care facility with a critical shortage. It also makes provision for nurses seeking advanced degrees to qualify for loans if they agree to take faculty positions, loans that are canceled once they fulfill the requirement. In addition, the act authorizes grants for nursing schools to provide training for geriatric care, as well as grants to hospitals to improve work environments. However, funding for this program must be reauthorized yearly, which makes it important that voters indicate their support for such funding to their legislators.

- **Increase the pool of available home health care workers by increasing the number of visas for low-skilled workers.** A coalition representing the home health care industry lobbied Congress in 2006 for a new visa program that they "hoped would annually admit 400,000 low-skilled workers—the grist of the home-care field—which would be equal to the number [of such workers] that now arrive illegally." There was strong opposition to the idea on the grounds that it would hurt the wages of native-born American low-skilled workers. As a result, the "proposed number of low-skill visas was cut in half."[43] Those who supported the increase argued that native-born Americans were not willing to take those jobs, and that therefore it would not adversely affect them. Support for that argument can be found in a recent analysis of the impact of immigration in California over the 1990–2004 period, which shows that while immigration does have a negative impact on the wages of previous immigrants, the effect of such immigration was "positive on the wages of U.S. natives." In fact, the analysis revealed that "native real wages are boosted by 4.1%, on average, by immigration."[44]

- **Improve the reimbursement of home health care aides and provide them with such benefits as health insurance and sick days.** Although there will be costs involved, everyone who now has a relative or friend receiving home care, or who anticipates needing such care for someone they know or eventually for themselves, should think of the dangers of not improving salaries and benefits for home health care workers. Do you really want someone with the flu taking care of a frail individual because they cannot afford a day off and cannot pay to visit a doctor? In the end, we will all benefit by accepting the costs for such a change, even if it is made out of self-interest rather than altruism.

VI. Conclusion

Many of these recommendations will be costly, but the alternative is to sentence the oldest old to years spent in conditions no American would want to endure. Former Senator Bill Bradley recently wrote that "Americans historically have not been narrow, selfish or preoccupied with the present at the expense of the future. We have been open, generous, expansive, forward looking, creative, egalitarian and optimistic. And that's who we still are today."[45] It is in all our best interests to prove that he is right. For the boomers, the group that worked so tirelessly for civil rights and women's liberation and an end to the war in Vietnam, long-term care is the next issue calling for their attention. If they fail to heed that call, it is at their own peril.

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