

"The Unnecessary Tragedy of Long-Term Care: A Guide for Medical Doctors"

by
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I wrote this article in 2002 to encourage medical doctors to advise their patients to plan for long-term care. While some of its statistics and citations are outdated, I believe this message is as important today as it was a quarter century ago.

Part One: "Ominous Parallels--Medicine and LTC"

If you like what happened to American medicine in the past three decades, you'll love what's happening to long-term care today. If not, read on. You can do a wonderful thing for your patients, your colleagues, your parents, yourselves and your country by helping everyone understand and avoid this unfolding tragedy. Just as physicians and their patients have lost control of health care decisions to impersonal "third-party payors," our most vulnerable aging citizens and their long-term caregivers are suffering a similar fate today. Because of your professional position and the respect you command, medical doctors are uniquely positioned to advise a wide ambit of people about the risk and cost of long-term care. With a little objective information, you can help them and yourself minimize the risk and prepare for the costs. You can also contribute toward solving a major social problem for America. These four brief articles will tell you what you need to know about the unnecessary tragedy of long-term care.

You already know what happened to acute health care over the past century. Employer-sponsored, tax-favored, low-deductible, private health insurance convinced consumers that health care was a "right." They consumed accordingly and drove the cost of health care through the roof. When poor and elderly people could no longer afford medical care, Medicaid and Medicare started paying for them. That went well at first, but demand and cost gradually shot up for these publicly financed programs too. So, government ratcheted down reimbursement and ratcheted up regulations and controls. Medicare instituted a prospective payment system which pressured physicians to discharge patients "quicker and sicker." Similar cost pressures led private insurers to pursue "managed care," by which they hoped to save money by co-opting care management from doctors and their patients. Some of them pursued managed care right into bankruptcy. Today, insurers and providers are dropping out of Medicare managed care programs as fast as medical doctors are dodging low-pay Medicaid patients. We're well on our way to a three-tiered health care system with "concierge care" for the rich, managed care for the middle-class, and low-cost Medicaid-financed care for the poor.

Now let me tell you something you may not already know. Long-term care for the elderly and disabled has followed a similar path. Life expectancy increased rapidly from 47 to nearly 80 years in the last century. By the early 1960s, people were living longer and dying slower, often in homes for the aged at considerable expense. Women, who traditionally provided care for elderly relatives in the home, were less available for caregiving as they entered the formal workplace. Left to their own devices, consumers would have demanded, and the market would have provided, low-cost home and

community-based services for long-term care, such as chore services, adult day care, home care and assisted living. People would have ended up in nursing homes only as a last resort when 24-hour-a-day skilled care was required. But that's not what happened.

Instead, in 1965, Medicaid began paying for nursing home care. In the beginning, the program had few eligibility restrictions and paid nursing homes generously. You can guess what happened next. The public isn't stupid. They put grandma in a nursing home, whether she needed that level of care or not, because the government paid for nursing home care. The nursing home industry isn't stupid. They built new nursing homes as fast as they could raise the walls. Before long, demand and cost skyrocketed. So, Medicaid capped the bed supply and the reimbursement rates. Of course, with supply and price capped, demand skyrocketed. As nursing homes could fill all their beds easily by accepting low Medicaid reimbursement rates, quality plummeted. Lucrative private payers migrated to more desirable assisted living facilities, but most people could not afford formal long-term care in any venue. Unfortunately, the public has not saved or insured for this risk, because the government has been giving long-term care away for nearly 40 years.

So here's where we find ourselves today. America has a nursing-home-based, welfare-financed long-term care service delivery system that is faltering. Several nursing home chains have declared bankruptcy and eight percent of all nursing home beds in the country remain in bankrupt facilities. Low Medicaid and Medicare reimbursements, accounting for nearly 80 percent of all patient days, have undercut the nursing facilities' ability to attract quality caregivers. Staff shortages led to poor care, lawsuits, staggering court settlements, and skyrocketing liability insurance premiums. Surveys show many seniors would rather die than move permanently to a nursing home. Yet, more desirable, private-pay "assisted living facilities" are filling too slowly to be profitable. All long-term care stock prices are in the cellar. Our country's home and community-based care infrastructure, where most people would rather receive long-term care, is severely underdeveloped. Most middle-class Americans cannot afford formal long-term care services, but few—only seven percent of seniors and hardly any baby boomers—have private long-term care insurance to pay for the services they need. Finally, an "age wave" of baby-boomer retirees will exacerbate these problems exponentially by the end of the decade.

What's wrong and what can we do about it?

Part Two: "First Do No Harm"

Our parents and grandparents fought two great wars to make the world safer and more free for us. They struggled through the Depression, scrimped and saved, so we could enjoy greater prosperity. For the past four decades, however, we have rewarded their long, hard efforts with an inadequate long-term care system based on nursing-home institutionalization and welfare financing. Most people would agree we owed our "Greatest Generation" better treatment. Surely, no one believes the current service delivery and financing system can meet future needs. Our challenge today is to find and

finance a better way of providing long-term care before time runs out for us baby boomers. Otherwise, we will leave an even bigger problem for the next generation. We must not fail our children as we have let down our own parents and grandparents. The demographic clock is ticking.

Part One of this four-part series explained how long-term care in America sank to its current sorry state. In Part Two, we will address the question: "Is the medical profession part of the problem or part of the solution for long-term care?" At first glance, the answer does not seem encouraging.

"Teach them this art" says the Hippocratic Oath. Unfortunately, America already faces a severe shortage of trained and qualified geriatricians. The Alliance for Aging Research recently reported that "the U.S. currently needs 20,000 physician-geriatricians to care adequately for our population of 35 million older people. Yet of the 650,000 licensed physicians practicing in the U.S., fewer than 9,000 physicians have met the qualifying criteria in geriatrics." Nor is the outlook promising for the future. The report continues: "Furthermore, this number is projected to decrease to as few as 6,100 by 2004. The U.S. will fall far short of the 36,000 geriatricians needed by 2030 unless effective steps are taken to train new providers." (Footnote 1) [[Update](#): As of 10/23/25, there were fewer than 7,500 board-certified geriatricians in the U.S.]

Can primary care physicians compensate for this shortage of geriatrics specialists? Perhaps, but evidently, not yet. According to Patricia P. Barry, MD, MPH, Executive Director of the Merck Institute of Aging and Health (MIAH), speaking on the release of the MIAH Physician 2002 Survey: "Only half of the physicians we surveyed believe that their colleagues can adequately treat a number of common geriatric conditions, such as falls, memory loss and incontinence, and only about one in three believe they can treat sensory impairments. These disturbing numbers imply that older adults are not getting the care they need to live longer and better lives. Obviously, there's a definite gap between what primary care physicians know, and what they need to know, to ensure that their older patients not only survive but thrive." (Footnote 2)

Service delivery, however, is only part of the problem of long-term care. People also have to be able to pay for the services they receive. Unfortunately, most professional long-term care is provided in nursing homes today and paid for by Medicaid. Medicaid is a means-tested public assistance program, i.e. welfare. It has a dismal reputation for problems of poor access, doubtful quality, low reimbursement, frequent discrimination, and institutional bias. Many seniors see admission to a Medicaid nursing home as a sentence worse than death. To purchase quality long-term care in their home or an assisted living facility, the preferred venues, or in the better nursing homes, people must be able to pay privately. To pay privately, however, they need substantial assets or private insurance. At an average of \$55,000 per year for nursing home care, over \$25,000 for assisted living, and even more for round-the-clock home care, only the most prosperous of the elderly can afford the cost. [[Update](#): the corresponding numbers as of 2025 are \$115,000 per year for nursing home care and \$74,000 for assisted living.]

Are medical doctors educating their patients about the financial risks of long-term care and encouraging them to prepare? Surely some are, but not enough. The only hard evidence we have is that certain physicians have succumbed to the siren's song of "Medicaid estate planning." Medicaid planning is the practice used by some "elder law" attorneys to impoverish infirm elderly people prematurely and artificially. The purpose of Medicaid planning is to qualify the senior for welfare-financed nursing home care while diverting his or her assets to an early inheritance for an heir. Usually the heirs are the clients and the vulnerable seniors (and taxpayers) are the victims of Medicaid planners. Medicaid planning has such a bad reputation nowadays that it is practiced, although widely, mostly in the shadows. Ten years ago, however, law and medical journal articles co-written by lawyers and physicians with advice like this were commonplace: "[L]awyers specializing in welfare law can assist individuals in obtaining public entitlements and preserving private assets. . . . Physicians can make an important contribution to the welfare of their patients who are at risk by informing them of such services. . . ." (Footnote 3) Physicians who follow the Hippocratic Oath will "abstain from whatever is deleterious or mischievous," eschew such advice, shun the practice of Medicaid planning, and advise their patients to do the same.

Clearly, the medical profession is less than fully prepared to provide long-term care services and good advice about long-term care financing to America's elderly. By the time baby boomers, who are turning 50 every eight seconds, start turning 85 nearly as fast, it will be too late. What can one physician do? We'll answer that question in Part Three of this series.

Footnotes:

(1) Alliance for Aging Research, "Medical Never-Never Land: 10 Reasons Why America's Not Ready for the Coming Age Boom," February 2002, p. 4.

(2) Statement by Patricia P. Barry, MD, MPH, Executive Director of the Merck Institute of Aging & Health (MIAH) on the release of the MIAH Physician 2002 Survey.

(3) Feinbloom, Richard I., M.D., and Ira S. Schneider, J.D., "Protecting Assets During Catastrophic Illness Through Financial Planning: The Physician's Role," *The Journal of the American Board of Family Practice*, Vol. 1, No. 1, Jan-Mar 1988, pages. 46-49.

Part Three: "What Can One Physician Do About Long-Term Care?"

Long-term care in America is an unnecessary tragedy. Millions of good people suffer its ravages excessively. The emotional and financial pressures of caring for elderly loved ones tear families apart. A good service delivery and financing system for long-term care would go a long way to mitigate the devastation caused by Alzheimer's, Parkinson's and stroke.

Unfortunately, America's nursing home based, welfare-financed long-term care system is in a terrible state of disrepair. Well-intentioned, but ill-conceived public policies have

created perverse economic incentives that cause most Americans to ignore the risk of long-term care until too late. Once stricken by the chronic illnesses of old age, elders and their families have nowhere else to turn for care and asset protection but to Medicaid.

Ostensibly a welfare program, Medicaid has become the major third-party payor for long-term care in America, covering nearly 80 percent of all nursing home patient days. As the old adage says: "Programs for the poor are poor programs." Low Medicaid reimbursements and heavy government regulations have driven most publicly financed long-term care providers to the brink, and many over the brink, of bankruptcy. Physicians are not exempt. Few economic incentives exist to attract medical doctors into the critically needed specialty of geriatric medicine.

What can one physician do? Plenty. —Here are some ideas for starters:

- First, make sure you are not one of the half of all physicians cited in Part Three of this article who are unprepared to treat common geriatric conditions. Expand your knowledge and hone your skills in this practice area.
- Learn the facts about long-term care risk. Seniors have a nine percent probability of a five-year or longer stay in a long-term care facility according to the *New England Journal of Medicine*. (Footnote 1) The journal *Medical Care* placed the risk at eight percent for a stay exceeding five years and two percent for a stay over 10 years. (Footnote 2) [[Update](#): these duration of stay estimates are outdated.]
- Learn the facts about long-term care cost. Nursing homes charge private payors \$55,000 per year on average, but fees range from \$35,000 in some rural areas to over \$100,000 per annum in certain major metropolitan areas. Assisted living facilities average half the cost of nursing homes, but their charges also range widely depending on the breadth and quality of their services. Full time home care for chronic long-term illness is affordable only by the most affluent elderly.
- Visit three nursing homes--a 100-percent Medicaid facility, a 100-percent private pay facility, and a facility with a mixture of privately and publicly financed residents. Your five senses, especially smell, should tell you where you, your loved ones, or your patients would prefer to reside if and when care in a skilled nursing facility becomes necessary.
- Visit an assisted living facility (ALF) or two. ALFs are the modern, mostly private-pay alternative to nursing home care. They're like hotels where you can call room service for help taking a bath or leave a call at the desk to be reminded to take your medications. Assisted Living Facilities provide three meals a day in a restaurant-like setting or in one's room. They maximize the social aspects of residence while minimizing the institutional feeling.
- Understand that the key to obtaining quality long-term care at the most appropriate level, i.e. home care, assisted living, and nursing home care only as a last resort, is the

ability to pay privately. To pay privately without spending down personal income and assets requires special, private insurance protection. Managed care, major medical and Medicare supplemental insurance do not cover long-term custodial care.

- Read extensively about private long-term care insurance and interview one or more insurance agents or financial planners who have proven expertise in this complicated product. Two good sources of information are "Long-Term Care Planning: A Dollar & Sense Guide" published by the United Seniors Health Cooperative. For a book-length treatment, try Phyllis Shelton's *Long-Term Care: Your Financial Planning Guide*. (Footnote 3)
- Focus on the tax benefits of purchasing private long-term care insurance for yourself, your family, and your employees. According to *J.K. Lasser's Choosing the Right Long-Term Care Insurance*, "To encourage more corporations to offer their employees long-term care insurance, the IRS says that these companies may generally deduct a portion if not the entire cost of the premium as a business expense." (Footnote 4)
- Become proactive. Recommend this series of articles on long-term care to your friends, family, patients, colleagues, and others. Nearly forty years of government-financed nursing home care have anesthetized the public to the risk and cost of long-term care. Wake them up! Be a Paul Revere of long-term care. In the long run, providing and financing long-term care for the aging baby-boom generation may be as important to America's well-being as homeland security is today.

A wag once said "The best way to help the poor is not to become one of them." The single biggest financial risk seniors face is a long-term nursing home or assisted living stay incidental to one of the chronic illness of old age. To eliminate that risk and assure access to quality long-term care, people must plan early to save, invest or insure for long-term care. The more people can be persuaded to take personal financial responsibility for long-term care, the better able Medicaid and Medicare will be to pay for the care of those who cannot care for themselves. As a trusted medical professional, you can influence your patients, colleagues and fellow citizens to prepare. Please do it!

Footnotes:

(1) Peter Kemper and Christopher M. Murtaugh, "Lifetime Use of Nursing Home Care," *New England Journal of Medicine*, Vol. 324, No. 9, February 28, 1991, p. 597.

(2) Christopher Murtaugh, Peter Kemper, Brenda C. Spillman, and Barbara Lepidus Carlson, "The Amount, Distribution, and Timing of Lifetime Nursing Home Use," *Medical Care*, Vol. 35, No. 3, 1997, p. 212.

(3) Phyllis Shelton, *Long-Term Care: Your Financial Planning Guide*, Kensington Books, New York, New York, 2001. Also Marilee Driscoll's "The Complete Idiot's Guide to Long-Term Care Insurance."

(4) Benjamin Lipson, *J.K. Lasser's Choosing the Right Long-Term Care Insurance*, John Wiley & Sons, Inc., New York, NY, 2002, p. 59.

Part Four: "For the Benefit of My Patients"

Some of your patients and their families are suffering unnecessarily. The malaise is long-term care. You can be a remedy. The Hippocratic Oath says "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients" Make it part of your professional regimen to understand the complicated issue of long-term care. Consider both the medical and the financial aspects. Advise the people whose lives you touch wisely on this subject.

This is the last of a four-part series of articles on long-term care service delivery and financing. Its primary purpose is to encourage physicians who have not yet read the first three parts to do so. If you've read the foregoing articles, then this one is a summary and reminder. Email, fax or snail-mail this article to friends, family members, patients and colleagues. Encourage them to take the long-term care issue as seriously as you have.

Long-term care is already a severe problem. With the aging of the baby boom generation, it will become an epidemic. Even as the challenges of retirement security (Social Security) and acute health care (Medicare) for the elderly remain unsolved by government, long-term care looms just around the next bend in public policy as the 800-pound gorilla of social problems.

Today, 80 percent of all long-term care services are provided informally by friends and family of frail and infirm elderly in their homes. Women especially are sacrificing their time and often their livelihoods to care for ailing parents and in-laws. Daughters, wives and sisters go to great lengths to avoid placing their loved ones in nursing homes, because nursing homes have such a negative reputation.

Nevertheless, most formal, professional long-term care services *are* provided in nursing homes and they are paid for by Medicaid, a welfare program on the verge of insolvency. Other, more desirable levels of care and the investment or insurance products to pay for them have evolved very slowly. This is true because heavy government financing of nursing home care over the years has desensitized the public to the risk of long-term care and skewed the delivery system toward institutionalization.

For over a decade, Medicaid estate planning attorneys have eased the way onto welfare-financed nursing home care for the middle and upper-middle classes. Imagine how easy it is for a lawyer to garner clients by waving a magic legal wand after the insurable event has occurred. Compare that to the challenge facing long-term care insurance agents. Agents must convince healthy prospects to purchase expensive insurance against a risk they're in denial about and for which the government pays anyway, however inadequately.

Studies indicate that a primary reason for the deficiencies in America's long-term care system is the inadequacy of nursing home financing provided by Medicaid and Medicare. (Footnote 1) Low reimbursements drag down quality, invite liability lawsuits, and cause the continuing downward spiral. Even to gain admission to the better nursing homes nowadays, people need "key money" sufficient to pay privately for at least a year. Assisted living facilities, the highly desirable alternative to nursing homes, are almost entirely private pay. Experts express little or no hope that national social health insurance will ever ameliorate, much less eliminate, these problems.

Low Medicaid and Medicare reimbursement rates have also discouraged physicians from accepting new patients dependent on these government payment programs. This fact may also account for the dearth of doctors, nurses, and other medical professionals who pursue and practice geriatric specialties.

In a nutshell, long-term care service delivery and financing in America is in serious trouble. The only practical way for individuals to ensure access to quality long-term care at the most appropriate level—home care, assisted living and nursing home care only as a last resort—is to be able to pay privately. But the cost of long-term care is comparable to the cost of one's house burning down, while the probability this catastrophic event will occur is much higher.

Medical doctors should study the issue of long-term care, learn about the risks of Medicaid dependency, investigate the alternative of private long-term care insurance protection, and use your influence with family, friends, and patients to become part of the solution to this challenging national dilemma.

Footnotes:

(1) Center for Long-Term Care Financing, *The LTC Triathlon: Long-Term Care's Race for Survival*, Seattle, 2000, <http://www.centerltc.com/pubs/triathlon.pdf>.