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Aging and Long-Term Care in Nebraska

James A. Thorson
University of Nebraska at Omaha

Burce J. Horacek
University of Nebraska at Omaha

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A high proportion of Nebraska's population is age 65 or older and this is the fastest growing segment of the population. The population aged 85 years and older, which is the population most in need of long-term care, grew by over 45 percent between 1970 and 1980, and is expected to increase by 202 percent by the year 2000. This group includes individuals who are likely to require public assistance to help meet their medical and long-term health care needs. We estimate that the cost to the state to provide Medicaid assistance will increase from $60.4 million to $164.5 million over the next 15 years.

Issues of increasing importance and complexity revolve around the aging population. This is especially true in Nebraska, one of the "oldest" states. A brief overview of some of the most relevant issues are presented; then, we focus on an issue of immediate and long-term concern to Nebraska's policymakers—institutional care of the aged.

Overview

The number of older people in the state and the nation has increased tremendously during this century, and it will continue to increase, along with the percentage of our population that is older than 65. U.S. Bureau of the Census (1984) figures indicate that in 1900, there were about 3 million Americans over the age of 65, about 4 percent of the U.S. population. In 1985, there were more than 28 million individuals in this group, making up almost 12 percent of the U.S. population. Projections are that by the year 2000, there will be 35 million older persons living in the United States. These individuals will certainly have a great impact on economic, social, and health programs, such as Social Security, Medicare, and Medicaid.

Social and Economic Well-being

Perhaps the most dramatic increase is projected to occur in the 75 year old and older age group. During the next 50 years, the portion of the

population that is 75 years old or older is projected to increase by more than 300 percent, and will represent 10 percent of the total population. These projections cause speculation about the future course of events in the United States.

Neugarten and Havighurst (1979) suggest that we will see a two-tier group of the aged. The first group, ages 55-74 years, they call the young-old, and the second group, 75 years and older, they call the old-old. These two groups will not only be separated chronologically, but their needs and characteristics will be quite different. Namely, the old-old group could be in far greater need of intervention programs to maintain economic, social, and physical well-being. In Nebraska, we will not see a great increase in the portion of the population that is 65 or older until the next century, but a proportionate increase in the old-old population will affect the state, both in the short-term and the long-term.

Our shifting population patterns pose difficult policy options for public decisionmakers, service agencies, researchers, educators, and others who are interested in the social, economic, and health needs of the elderly. The growth of the older population has prompted policymakers to regard the elderly as primary recipients of government attention. Since the passage of the Social Security Act of 1935, the federal government has become increasingly involved in the development and implementation of programs that affect the elderly. We now find governmental intervention programs in diverse areas, such as income maintenance, health care, housing, transportation, nutrition, and various social services. These intervention policies for the elderly have proliferated to the point that in fiscal year 1985, benefits and services for the aged accounted for 27 percent of all federal outlays (Storey, 1986).

How can we gauge the social and economic well-being of the elderly? One approach is to examine issues of concern or problems identified by older people. In a study commissioned by the National Council on Aging, Louis Harris (1981) identified many concerns. Over 42 percent of the individuals aged 65 and over identified "the high cost of energy," including gas, electricity, and oil, as being a serious problem. While this seems like a high percentage, 43 percent of those aged 18-64 years, also put the high cost of energy at the top of their list of problems. Consequently, concerns about high energy costs are shared by all Americans.

Second on the list of serious problems in the Harris poll was the "fear of crime." This concern was mentioned by 25 percent of those who were

65 years old and older as being a very serious problem. Twenty percent of the group aged 18-64 years mentioned fear of crime as being a serious concern.

"Poor health" was identified as a very serious issue by 8 percent of those who were 18-54 years old, 16 percent of those who were 55-64 years old, and 21 percent of those who were 65 and older. Furthermore, it was a greater concern for those with lower incomes; 31 percent of older Americans who had annual incomes under $5,000 identified poor health as a very serious problem. Among older minorities, 35 percent of blacks and 48 percent of Hispanics listed poor health as a very serious problem.

Older Americans were also concerned about not receiving "enough medical care." About 9 percent of older Americans listed this as a very serious problem, whereas 16 percent of older Americans with incomes under $5,000, 17 percent of older blacks, and 33 percent of older Hispanics considered this to be a very serious problem. Similarly, 18 percent of older Americans listed the cost of doctors' visits, 19 percent mentioned the generally high cost of medical services, and 18 percent listed transportation to and from medical facilities as being serious problems.

In the Harris study, two other issues were identified by older persons as being very serious problems by more than 10 percent of the sample. "Not having enough money to live on" was listed by 17 percent of those who were 65 and older, and "loneliness" was mentioned by 13 percent of older Americans. Loneliness tended to be more of a problem for older persons, whereas not having enough money to live on was more of a concern for younger adults.

How well-off are the elderly? While older persons identified many serious concerns in the Harris poll, most older people, especially the young-old, have a reasonable level of economic and social well-being. According to the U.S. Bureau of the Census, about 3.3 million elderly persons were living below the poverty level in 1984. This translates to a 12.4 percent poverty rate for older persons, however, this rate is lower than the poverty rate for persons under age 65 (14.7 percent). Adding in the near poor (those with incomes between the poverty level and 125 percent of the poverty level), an additional 2.4 million individuals, about 21 percent of the older population, were poor or near-poor in 1984. The rates in Nebraska tend to be close to the national average.

Older persons who live alone or with nonrelatives are more likely to have low incomes, with about half reporting annual incomes of $7,000 or

less. Older women had a higher poverty rate (15 percent) than older men (9 percent). The major source of income for older families and individuals (noninstitutionalized population only) was Social Security (37 percent), followed by earnings and asset incomes (23 percent each), public and private pensions (15 percent), and payments, such as supplemental security income, unemployment, and veterans' payments.

As the 1981 Harris study pointed out, older Americans are no more likely than younger Americans to feel pinched financially. There are several reasons for this, including the fact that the elderly often have paid off their mortgages. Over 60 percent of older Americans own their homes and usually have relatively low monthly housing expenses. On the other hand, only 12 percent of those aged 18-54 have bought and fully paid for their homes (Harris, 1981). In addition, usually older individuals have fewer expenses connected with educating their offspring and fewer job-related expenses. Consequently, while about 21 percent of older persons can be categorized as poor or near-poor, most have much more discretionary income than younger families. According to one estimate (Petre, 1986), households headed by individuals who are 50 years old or older control half of the discretionary dollars in the United States.

Health Status and Needs of the Elderly

The health of older people is determined by medical, social, financial, and behavioral factors. Health policy in this country has stressed medical care and played down other factors. All of these factors are important when dealing with the health status of the elderly.

Older people have fewer acute conditions than do younger people, but far more chronic long-term illnesses, such as arthritis, hypertension, cardiovascular problems, diabetes, and cancer (Hickey, 1980). Estimates are that over 75 percent of the individuals who are over the age of 65 have one or more chronic illness. However, most of these individuals are able to continue living without major limitations in their daily activities. Health status varies widely in old age as at any other time in the life cycle. Good health does not necessarily imply the total absence of disease, but rather that medical conditions do not significantly interfere with physical and social functioning (Kermis, 1986).

The number of days in which ordinary daily activities are restricted because of injuries or illnesses increases with age (American Association

of Retired Persons, 1985). In 1982, older people averaged 32 days of restricted activity, as opposed to 12 such days for younger persons. Approximately half of these restricted days were spent in bed. In addition, the need for functional assistance increases sharply with age. Excluding the institutionalized elderly, about 5 million older persons needed the assistance of another person to perform one or more daily activities involving personal care or home management. This represents almost 20 percent of the noninstitutionalized elderly. These figures increase dramatically between the young-old and the old-old. In 1982, the percentages ranged from 13 percent for those aged 65-74; 25 percent for those aged 75-84; and 46 percent for persons who were 85 and older. Personal care activities include bathing, dressing, eating, and walking. Home management activities include shopping, preparing meals, taking medications, performing routine chores, and using the telephone.

About one in five older people are hospitalized each year, as compared with about 9 percent of people under age 65 (American Association of Retired Persons, 1985). The elderly also have a greater chance than younger people of being hospitalized each year, and they tend to have longer hospital stays (10 days versus 7 days). In 1982, the elderly averaged eight visits to a physician, as opposed to five visits for younger persons.

In 1984, older persons represented 12 percent of the population but expended 31 percent of the health care dollars in the United States. This totaled $120 billion, with an average expenditure of over $4,000 per older person. This is more than three times the average amount spent for health care by those who are under age 65 ($1,300). About two-thirds of the health care expenditures for the elderly came from government programs, including Medicare and Medicaid. Beyond government payments and private health insurance, older persons average about $1,000 in out-of-pocket costs each year. Cost increases for health care, combined with the growing number of elderly persons, are causing severe strain on federal and state budgets.

Service Needs and Alternatives

Although more than 20 percent of the elderly are limited in their daily activities and need some kind of assistance on a regular basis, only about 5 percent are in old-age institutions or hospitals at any time. Over 1

million of these persons reside in nursing homes (Eustis, Greenberg, and Patten, 1984). Consequently, while the percentage of individuals who are 65 and older and who reside in nursing homes is small compared with the entire elderly population, the numbers are significant. Also, while less than 5 percent of the elderly reside in old-age institutions at any time, indications are that an older person has about a 50 percent chance of being institutionalized at some time.

Chances of institutionalization increase with advancing age. About 1 percent of the young-old (65-74 years old) are in nursing homes. About 7 percent of individuals in the 75-84 age group reside in these institutions, and, among those 85 and older, 20 percent reside in nursing homes. Over 70 percent of nursing home residents are women, with the proportion of women increasing with age (Eustis, et al., 1984).

While long-term care is usually associated with a formal network of institutions and agencies, such as nursing homes, hospitals, and adult day centers, evidence suggests that a growing informal support network is providing substantial long-term care services to more than 3 million elderly individuals (Eustis, et al., 1984). The existence of this informal support network, which usually consists of family members, argues against the conclusion that American families dump their elderly members into nursing homes (Brody, 1979). In fact, most families will run out of options before considering institutional placement.

Ultimately, many older persons require some form of institutional care. On the other hand, many of the aged could avoid or delay being institutionalized if alternative services were available. One factor that contributes to institutionalization is the lack of health care and other social service assistance. Conversely, many institutionalized persons could probably be maintained at home with help from the following types of home-based and community-based assistance programs.

Physician and Physicians' Assistant Services. Most physicians argue that most house calls are unneeded and that better treatment and evaluation are provided in the physician's office or at a hospital. However, many older people, especially those in rural areas and small towns without physicians, find it difficult to get to a physician and may have to travel long distances to get service. Another problem in the delivery of health care to the elderly is that physicians' training in geriatric medicine is still in its infancy.

There are two bright spots in the availability of medical services to older people. The physicians' assistant (PA) program is one example of

a new type of health care delivery. Currently, almost 100 programs throughout the United States train prospective PAs in general medicine, anesthesiology, cardiology, ophthalmology, orthopedics, pathology, radiology, general surgery, and urology. One of these programs is at the University of Nebraska Medical Center in Omaha. Many opportunities exist for PAs in geriatrics, especially in rural areas where they can help fill the gap in care for older persons.

Another bright spot in the delivery of medical services to the elderly has been the development of geriatric assessment centers, most of which are associated with teaching hospitals in urban areas. These centers use physicians, nurses, social workers, and others who have been trained in geriatrics to diagnose and treat older persons and to refer them to appropriate medical and social services. Nebraska has two geriatric assessment centers in Omaha: one is connected with Creighton University (St. Joseph's Hospital) and the other is at the University of Nebraska Medical Center.

Nursing Services. Nursing continues to be one of the very few professions that routinely offers care in homes, hospitals, and other health care centers. Nurses can provide a variety of services to older persons, including visiting families in their homes, informing people about community health resources, providing nursing care for individuals with acute and chronic illnesses, gathering information regarding nursing homes and other institutions, and staffing public health clinics (Butler and Lewis, 1982). One organization of nurses that provides home care for the elderly is the Visiting Nurse Association (VNA). The VNA also operates clinics in most urban areas.

Homemaker and Home Health Services. Homemaker services describe a range of homemaking activities, such as shopping, laundering, and preparing meals. A home health aide is a person who can perform a variety of functions, including taking vital signs, assisting with various therapies, and giving baths. Often the homemaker and health aide are the same person. The goal of this practitioner is to assist the person in performing activities of daily living.

Friendly Visitor and Telephone Reassurance. Friendly visitor services have been available in many communities for decades. Visitors are often trained volunteers who provide many services to the elderly in their homes. One of the most important services they provide is companionship, but they also are trained to recognize health, nutritional, and other problems and to alert others to these developing problems. Friendly

visitors are sometimes connected with public welfare agencies, but they are often associated with churches and other organizations.

One variation of the friendly visitor service is the Senior Companion Program, a federal program administered by ACTION, that employs low-income persons over the age of 60 and pays them a small hourly stipend. This is an excellent example of older persons helping other older persons to maintain themselves in their homes. Several Senior Companion Programs operate in Nebraska. Telephone reassurance programs use the telephone to offer services that are similar to those delivered by friendly visitors. More often than not, these programs are run by volunteers who are connected with churches and service organizations.

Nutritional Services. Nutritional services for the elderly were developed because evidence showed that many older people were at risk and suffering from malnutrition and dehydration. Two federal programs have had a great impact on funding nutritional services for the aged. In 1964, Congress passed the Food Stamp Act which allowed eligible needy people to use food stamps to purchase food at neighborhood stores. In 1972, Congress passed an amendment to the Older Americans Act which established a national program for providing one nutritionally planned hot meal a day, usually 5 days a week, for people who are 60 years old and older. The focus of this act was to develop congregate meal sites to serve needy and isolated older persons, although no income criteria were established for using such a service. Partial funding for transportation to and from such sites was also provided.

Besides providing nutritional services to older Americans, this program also tried to provide opportunities for socialization among older people by focusing on congregate meal sites. The Meals-on-Wheels Program allows meals to be delivered to persons who are unable to attend congregate sites. Presently, Meals-on-Wheels provides over 1 million meals daily to older persons in all 50 states. In Nebraska, every Area Agency on Aging operates or contracts meal sites and Meals-on-Wheels Programs.

Legal Services. The legal needs of older persons include a variety of issues, such as income; taxes; federal, state, and local governmental benefits; and housing. In addition, assistance is often needed in the areas of guardianship, conservatorship, and protective services. Income tax preparation assistance is often provided by the Area Agency on Aging.

Eight years ago, the National Junior League of Women developed and started sponsoring Volunteers Intervening for Equity (VIE). These locally based programs use trained older persons to provide many paralegal and advocacy services for the elderly. VIE programs operate in Lincoln and Omaha. Other legal assistance programs have been offered by local community organizations, including legal aid societies.

Information and Referral Services. Often, older persons with the greatest need for services are the least likely to know how to obtain them. Many community service agencies have attempted to inform the elderly of the various services that are available to them, such as income tax assistance, nutritional services, home handyman assistance, senior companion programs, and transportation. Telephone assistance, booklets, and outreach programs provide information for the elderly. Assistance is also available through the national network of area agencies on aging, many state and county welfare agencies, church organizations, and U.S. congressmen and senators. Each year the latter group publishes an *Older Americans Handbook* which offers basic information about local, state, and federal services for the elderly.

Day-care Services. The last decade has seen the development of geriatric day-care centers in the United States. The first day-care centers for the elderly were developed and operated in Europe in the 1940s. In the United States, day care is available to older persons who have some physical or mental impairments but who can remain in the community if various support services are provided. These centers offer ambulatory care to adults who do not require 24-hour institutional care. In most cases, this allows family members to work during the day and to keep parents in their homes. Clients are referred to such programs by attending physicians or by social service agencies. Care is often provided 8 hours a day, 5 days a week. Depending on the center, meals, transportation, medical and therapeutic services, and social activities are offered. Most day-care centers focus on psychosocial services, but some offer medical services as well. Some centers focus on a particular clientele, such as the chronically mentally ill or persons with Alzheimer's disease. Day-care centers are funded through various federal social service programs, such as Title XX, grants, donations, and private pay.

Nebraska has many day-care centers for the elderly, including four in the Omaha area: The Friendship Program Day Service Center, McAuley Bergan Center, Immanuel-Fontenelle Adult Day Services, and the New

Cassel Day Center. Madonna Professional Care Center in Lincoln also sponsors a day-care center.

Respite Care. Traditionally, the family has been considered the primary source of care for its members, including the old. Studies indicate that family members play an important role as caregivers when the health and well-being of an older relative is threatened. Generally, families do not abandon or dump their elderly members into institutions (Shanas, 1979).

Recently, a great deal of attention has been given to the effect of caregiving on family members, especially the stress that caregiving involves. Such responsibilities are time-consuming and physically and emotionally draining. Burnout caused by such care no doubt leads to institutionalization of the elderly in many cases. Therefore, support systems have been developed to assist families in caring for their elderly members. One such support system is respite care.

Respite care service is based on the theory that a break in the caregiving routine can restore the physical and emotional capacity of the caregiver and the person receiving care. Respite care is relief provided by an outside caregiver who stays in the home with a health-impaired older person while the primary caregiver is relieved to perform activities outside the home. The respite caregiver provides supervision and companionship, and can offer services such as giving medications, toileting, walking, and preparing meals.

Most respite care programs offer assistance for only short periods of time (1-4 hours, 1-2 days per week). Respite caregivers are, more often than not, trained volunteers. Respite care is still in its infancy and other models and types will be developed. Another form of respite care, common in Great Britain, provides care in nursing homes and hospitals for longer periods of time, for example, 1-30 days. This type of respite care enables the family caregiver to have an extended break.

Long-term Care Issues in Nebraska

Most older people, especially the young old, are doing quite well. For most, the transition into retirement is not much of a trauma, retirement income is adequate, most have family supports, and a variety of health and social services help many older people maintain their independence. And, while many older persons have a chronic health problem that limits their activities, most cope well and lead active lives.

There are those members of the older population, of course, who are more at risk and who have more of the problems that we usually associate with old age. The frail elderly are usually older, and with increasing age comes a greater likelihood of isolation, poverty, chronic illness, and institutionalization. Services through a network of agencies that are designed to keep people at home become less of an alternative. For many, there comes a time when the services provided by family and social service and home health agencies are not enough and nursing home placement becomes a consideration or a necessity.

The demographic revolution of the present century is that most people can now expect to live long enough to get old. Through advances in public health, sanitation, and control of infectious diseases, we can now anticipate that 75 percent of males and 80 percent of females will live into later life. At an earlier point in our history, half of all deaths occurred prior to age 15; this median point for human survival has now advanced to age 75, and about 20 percent can anticipate celebrating their 85th birthday. It is not quite true to say that we have extended the life span itself; the outside limit remains at about 110 years (Fries and Crapo, 1981). The average life expectancy, however, has increased greatly because most people now live out a greater proportion of their life potential.

Because 75 to 80 percent of all deaths occur in later life and because most people live long enough to die of a chronic condition, health care at the end of life now means geriatric care. And, to an appreciable degree, geriatric care increasingly means terminal care. Health care efforts for many older persons are devoted to maintaining functioning and achieving a balance that will allow the older person to remain independent for as long as possible.

Rehabilitation programs for the aged are one of the genuine achievements of our health care system during the past several decades. Many people can now enjoy more years of a higher quality of life because of the advances that have been made in geriatric care. However, the greatest expenditure of health care dollars for most people comes at the very end of life. Because of the conquest of infectious diseases, death itself has changed during this century, and the end of life for most means months or years of chronic illness and increasing debility. Death is no longer sudden, it takes time. Only about 20 percent of the population dies suddenly. The remainder usually die slowly, usually in institutions, such as hospitals or nursing homes.

Long-term care of patients in our society usually means entry into a nursing home. There are more than 19,000 nursing homes in the United States and over 200 in Nebraska. Most provide nursing care and rehabilitation services on a for-profit basis; most (85 percent) in Nebraska are intermediate care facilities (ICFs). The remaining 15 percent operate at the skilled level, a higher and more expensive level of care. Excluding costs for physicians' services and medications, the cost of nursing home care in Nebraska currently ranges from about $30 to $60 per day.

The expenses of about half of the patients in nursing homes in Nebraska are paid by the state's Medicaid Program, with a 60:40 federal-state split. Medicare will pay for up to 100 days of long-term care per individual. Private health insurance pays a comparatively small amount of the cost of nursing home care.

Medicaid pays the expenses of nursing home patients who have exhausted their personal resources. Some nursing homes in Nebraska have discharged patients to other facilities when they switched from private pay to Medicaid. Because of the passage of LB 782 in the 1986 session of the Nebraska General Assembly, this practice is now forbidden. Unfortunately, this will probably result in an increase in the number of nursing homes that refuse to admit Medicaid patients initially.

Entry into a nursing home is by no means inevitable. Some individuals never need long-term nursing care; they remain relatively healthy until they develop a fatal illness, and then they die at home or in a hospital. And, others are cared for at home by family members or other caregivers. Because most families consider institutionalization only as a final alternative, families typically exhaust all other options before they consider nursing home care. Because families make heroic efforts to keep older members out of nursing homes, those older people who have no family caregivers are over-represented in long-term care institutions. About 20 percent of the aged have no living children, but 40 percent of nursing home residents are isolates. Thus, older persons who have no children are twice as likely to be institutionalized.

Nebraska is one of the states with a high proportion of citizens aged 65 or older (13.4 percent in 1984), compared with the national average of 11.9 percent. And, this group is the fastest growing portion of Nebraska's population.

Table 1 shows that from 1970 to 1980 the population of Nebraska increased by 5.8 percent, the group aged 65 and older increased by 12.1 percent, and the group aged 85 and older increased by 45.3 percent. While still relatively small in terms of absolute numbers, the group aged 85 and older is significant in its need for services, with over 20 percent being institutionalized and over 40 percent needing personal care or assistance in the home. Because poverty increases with age, these are the people who are most likely to require public assistance for their medical and long-term care needs.

Table 1 also includes a projection of the portion of the population that will be 85 years old or older in the year 2000. Projections can be made with a fair amount of accuracy because we are dealing with living persons. But, two factors that may influence the actual outcome were not accounted for in our projection: out-migration, usually a phenomenon among younger adults, and mortality rates, assumed to remain constant at 1980 levels. The number of individuals 85 years old and older in the year 2000 is, thus, assumed to be 34.9 percent of those aged 65 and older in 1980. Should survival rates improve (which is likely), the projected number of individuals who are 85 years old or older will be higher than we have projected.

As can be seen, the projected increase in the number of individuals who are 85 years old or older for the state is 202 percent from 1980 to 2000. This phenomenal rate of growth will be exceeded in urban counties, such as Douglas (247 percent), Lancaster (209 percent), Sarpy (236 percent), Lincoln (247 percent), Platte (239 percent), and Scotts Bluff (269 percent). Towns that serve as service centers for farming areas will have a particularly high rate of growth in the 85 year old and older group. Traditionally, they serve as retirement areas and they are also the locations of hospitals and nursing homes. Thus, they may be areas of in-migration for the very old from surrounding counties.

By the year 2000, the 85 year old and older population in every county in Nebraska will at least double. The percentages for very small counties, however, are not especially meaningful. Tiny Blaine County, for example, had only nine residents who were 85 years old or older in 1980; thus, one death could have a dramatic effect upon the percentage. Overall, however, these figures are conservative. Nebraska will experience a population explosion among the very old into the next century.

Table 2 provides information about older persons who were living in poverty and receiving Medicaid assistance for long-term care in

Table 1 — Population gain or loss of the counties of Nebraska, 1970 and 1980

County	Total population			Population aged 65 and older			Population aged 85 and older			Projected population aged 85 and older in 2000	
	1970	1980	Change[1]	1970	1980	Change[1]	1970	1980	Change[1]	Change	
	— — Number — —		Percent	— — Number — —		Percent	— — Number — —		Percent	Number	Percent
Adams	30,553	30,656	0.3	4,648	4,790	3.0	454	649	42.9	1,672	158
Antelope	9,047	8,675	(4.2)	1,604	1,578	(1.0)	144	166	15.3	554	234
Arthur	606	513	(18.1)	55	76	38.2	4	10	150.0	27	165
Banner	1,034	918	(12.6)	89	101	13.5	1	7	600.0	35	400
Blaine	847	867	2.3	146	140	(4.3)	7	9	28.5	49	443
Boone	8,190	7,391	(10.8)	1,278	1,343	5.1	122	157	28.7	469	199
Box Butte	10,049	13,696	35.6	1,534	1,717	11.9	128	211	64.8	599	184
Boyd	3,752	3,331	(12.6)	711	737	3.6	46	66	43.5	257	289
Brown	4,021	4,377	8.8	683	796	16.5	79	95	20.3	278	193
Buffalo	31,222	34,797	11.5	3,816	4,162	9.0	410	494	20.4	1,453	194
Burt	9,247	8,813	(4.9)	1,713	1,849	6.8	155	235	51.6	645	174
Butler	9,461	9,330	1.4	1,649	1,792	8.7	145	209	44.1	625	199
Cass	18,076	20,297	12.3	2,308	2,601	12.7	257	319	24.1	908	185
Cedar	12,192	11,375	(7.2)	1,784	1,980	10.9	159	234	47.2	691	195
Chase	4,129	4,758	15.2	700	759	8.4	67	96	43.3	265	176
Cherry	6,846	6,758	(1.3)	882	997	13.0	60	117	95.0	348	197
Cheyenne	10,778	10,057	(7.2)	1,406	1,567	11.5	111	176	58.6	547	211
Clay	8,266	8,106	(1.9)	1,360	1,437	5.7	132	214	62.1	502	135
Colfax	9,498	9,890	4.1	1,811	2,030	12.1	155	239	54.2	708	196
Cuming	12,034	11,664	(3.2)	1,783	1,986	11.4	156	217	39.1	693	219

Table 1 — Population gain or loss of the counties of Nebraska, 1970 and 1980 (continued)

County	Total population			Population aged 65 and older			Population aged 85 and older			Projected population aged 85 and older in 2000	
	1970	1980	Change[1]	1970	1980	Change[1]	1970	1980	Change[1]	Change	
	— — Number — —		Percent	— — Number — —		Percent	— — Number — —		Percent	Number	Percent
Custer	14,092	13,877	(1.5)	2,508	2,725	8.7	254	328	29.1	951	190
Dakota	13,137	16,573	26.1	1,333	1,171	28.4	119	173	45.4	597	245
Dawes	9,693	9,609	(0.8)	1,294	1,404	8.5	118	183	55.1	490	168
Dawson	19,467	22,304	14.6	2,725	3,116	14.3	228	400	75.4	1,087	172
Deuel	2,717	2,462	(10.4)	477	530	11.1	42	69	64.3	185	168
Dixon	7,453	7,137	(4.4)	1,274	1,327	4.2	85	162	90.6	463	186
Dodge	34,782	35,847	3.1	4,572	5,418	18.5	414	666	60.8	1,890	184
Douglas	389,455	397,038	1.9	36,851	41,483	12.6	2,987	4,165	39.4	14,477	247
Dundy	2,926	2,861	(2.3)	572	593	3.7	68	69	1.4	207	200
Fillmore	8,137	7,920	(2.7)	1,519	1,573	3.5	176	256	45.4	549	114
Franklin	4,566	4,377	(4.3)	1,010	1,054	4.3	88	129	46.5	368	185
Frontier	3,982	3,647	(9.1)	639	620	(3.0)	58	69	18.9	216	214
Furnas	6,897	6,486	(6.3)	1,599	1,627	1.8	207	241	16.4	568	136
Gage	25,719	24,256	5.2	3,946	4,432	12.3	365	517	41.6	1,547	199
Garden	2,929	2,802	(4.5)	509	619	21.6	48	79	64.6	216	173
Garfield	2,411	2,363	(2.0)	482	533	10.6	53	39	(35.8)	186	377
Gosper	2,178	2,140	(1.8)	284	347	22.2	14	51	264.2	121	137
Grant	1,019	877	(16.2)	106	119	12.3	7	7	0	42	500
Greeley	4,000	3,462	(15.5)	636	673	5.8	38	84	121.0	235	179
Hall	42,851	47,690	11.3	5,106	5,964	16.8	401	700	74.6	2,081	197

Table 1 — Population gain or loss of the counties of Nebraska, 1970 and 1980 (continued)

County	Total population			Population aged 65 and older			Population aged 85 and older			Projected population aged 85 and older in 2000	
	1970	1980	Change[1]	1970	1980	Change[1]	1970	1980	Change[1]	Change	
	— — Number — —		Percent	— — Number — —		Percent	— — Number — —		Percent	Number	Percent
Hamilton	8,897	9,301	4.9	1,238	1,299	4.9	148	177	19.6	453	156
Harlan	4,357	4,292	(1.5)	850	920	8.2	63	98	55.5	321	228
Hayes	1,530	1,356	(12.8)	191	178	(7.3)	8	7	(14.3)	62	787
Hitchcock	4,051	4,079	.7	697	752	7.9	51	86	68.6	262	205
Holt	12,933	13,552	4.8	1,924	2,083	8.3	183	250	36.6	727	191
Hooker	939	990	5.4	174	190	9.2	27	31	14.8	66	114
Howard	6,807	6,773	(.5)	1,008	1,123	11.4	73	129	76.7	392	204
Jefferson	10,436	9,817	(6.3)	1,970	2,025	2.8	178	236	32.6	707	199
Johnson	5,743	5,285	(8.7)	1,034	1,152	11.4	91	142	56.0	402	183
Kearney	6,707	6,053	(10.8)	1,078	1,179	9.3	94	164	74.5	411	151
Keith	8,487	9,364	10.3	1,055	1,275	20.9	90	118	31.1	445	277
Keya Paha	1,340	1,301	(2.9)	168	205	22.0	11	19	72.7	72	279
Kimball	6,009	4,882	23.1	511	677	32.4	58	88	51.7	236	168
Knox	11,723	11,457	(2.3)	1,930	2,196	13.8	151	263	74.2	766	191
Lancaster	167,972	192,884	14.8	16,737	19,572	16.9	1,152	2,212	92.0	6,831	209
Lincoln	29,538	36,455	23.4	3,381	4,342	28.4	266	437	64.3	1,515	247
Logan	991	983	(.8)	129	145	12.4	6	13	116.7	51	292
Loup	854	859	.5	111	144	29.7	8	12	50.0	50	317
McPherson	623	593	(5.0)	74	105	41.9	5	3	(66.7)	37	1,133
Madison	27,402	31,382	14.5	4,074	4,580	12.4	335	552	64.8	1,598	189

Table 1 — **Population gain or loss of the counties of Nebraska, 1970 and 1980 (continued)**

County	Total population			Population aged 65 and older			Population aged 85 and older			Projected population aged 85 and older in 2000	
	1970	1980	Change[1]	1970	1980	Change[1]	1970	1980	Change[1]	Change	
	— — Number — —		Percent	— — Number — —		Percent	— — Number — —		Percent	Number	Percent
Merrick	8,751	8,945	2.2	1,255	1,406	12.0	125	156	24.8	491	215
Morrill	5,813	6,085	4.7	890	1,037	16.5	93	112	20.4	362	223
Nance	5,142	4,740	(8.5)	1,003	886	(13.2)	101	84	(20.2)	309	268
Nemaha	8,976	8,367	(7.3)	1,446	1,539	6.4	172	198	15.1	537	171
Nuckolls	7,404	6,726	(10.0)	1,361	1,335	(1.9)	115	177	53.9	466	163
Otoe	15,576	15,183	(2.6)	2,737	2,943	7.5	270	411	52.2	1,027	149
Pawnee	4,473	3,937	(13.6)	1,014	977	(3.8)	98	126	28.6	341	171
Perkins	3,423	3,637	6.3	548	638	16.4	39	84	115.4	223	165
Phelps	9,553	9,769	2.3	1,604	1,744	8.7	183	291	59.0	609	109
Pierce	8,493	8,481	(.1)	1,303	1,452	11.4	98	158	61.2	507	221
Platte	26,508	28,852	8.8	2,878	3,529	22.6	209	363	73.7	1,232	239
Polk	6,468	6,320	(2.3)	1,245	1,265	1.6	151	157	3.9	441	181
Red Willow	12,191	12,615	3.5	1,817	1,954	7.5	138	213	54.3	682	220
Richardson	12,277	11,315	(8.0)	2,459	2,536	3.1	237	365	54.0	885	142
Rock	2,231	2,383	6.8	385	396	2.8	30	39	30.0	138	254
Saline	12,809	13,131	2.5	2,485	2,612	5.1	226	386	70.8	912	136
Sarpy	63,696	86,015	35.0	1,824	2,909	59.5	163	302	85.2	1,015	236
Saunders	17,018	18,716	9.9	2,665	2,949	10.6	212	347	63.7	1,029	197
Scotts Bluff	36,432	38,344	5.2	3,760	4,989	32.7	364	471	29.4	1,741	269
Seward	14,460	15,789	9.2	1,935	2,215	14.5	189	269	42.3	773	187

Table 1 — Population gain or loss of the counties of Nebraska, 1970 and 1980 (continued)

County	Total population			Population aged 65 and older			Population aged 85 and older			Projected population aged 85 and older in 2000	
	1970	1980	Change[1]	1970	1980	Change[1]	1970	1980	Change[1]	Change	
	— — Number — —		Percent	— — Number — —		Percent	— — Number — —		Percent	Number	Percent
Sheridan	7,285	7,544	3.9	1,220	1,290	5.7	138	199	44.2	450	126
Sherman	4,725	4,226	(11.8)	736	875	18.8	52	112	115.4	305	173
Sioux	2,034	1,845	(10.2)	212	254	19.8	18	9	(100.0)	89	884
Stanton	5,758	6,549	13.7	799	799	0	65	104	60.0	279	168
Thayer	7,779	7,582	(2.6)	1,545	1,665	7.8	137	202	47.4	581	188
Thomas	954	973	1.9	129	119	(8.4)	10	6	(66.7)	42	600
Thurton	6,942	7,186	3.5	860	965	12.2	54	114	111.1	337	196
Valley	5,783	5,633	(2.7)	1,096	1,158	5.6	101	142	40.6	404	185
Washington	13,310	15,508	16.5	1,751	1,916	9.4	191	231	20.9	669	189
Wayne	10,400	9,858	(5.5)	1,264	1,366	8.0	85	128	50.6	477	273
Webster	6,477	4,858	(33.3)	1,455	1,131	(27.7)	132	178	34.8	395	122
Wheeler	1,054	1,060	.5	117	136	16.2	9	6	(50.0)	48	700
York	13,685	14,798	8.1	1,984	2,241	12.9	170	266	56.5	782	194
Total	1,483,493	1,569,825	5.8	183,526	205,684	12.1	16,341	23,744	45.3	71,784	202

[1]Values reported in parentheses are losses.

Source: Characteristics of the Population, General Population Characteristics, Nebraska, Census of the Population. U.S. Bureau of the Census. Washington, D.C.: Government Printing Office. PC80-1-B29, Pt. 29, June 1982, pp. 129-34.

Table 2 Medicaid expenditures for long-term care of individuals who are aged 65 and older, by county, Nebraska, 1984 and 1985

County	Population aged 65 and older			Medicaid expenditures for long-term care[2]						Change[3]
				1984			1985			
	Quantity	Percentage of total	Percentage living in poverty	Intermediate care facilities	Skilled nursing	Total	Intermediate care facilities	Skilled nursing	Total	
	Number	— — Percent — —		— — — — Dollars — — — —			— — — — Dollars — — — —			Percent
Adams	4,790	15.6	14.9	947,038	15,837	989,875	1,044,306	148,341	1,192,345	20.4
Antelope	1,587	18.3	26.7	386,642	1,863	388,505	383,188	—	388,188	(1.4)
Arthur	76	14.8	17.1	11,924	—	11,924	11,528	—	11,528	(3.4)
Banner	101	11.0	2.0	6,673	7,157	13,830	2,043	1,320	3,363	(311.0)
Blaine	140	16.2	15.7	44,803	—	44,803	49,316	—	49,316	10.0
Boone	1,343	18.2	20.8	387,711	—	387,711	370,160	463	370,623	(4.6)
Box Butte	1,717	12.5	15.0	389,569	34,536	424,105	430,452	30,660	461,112	8.7
Boyd	737	22.1	21.7	166,813	—	166,813	196,376	16,011	212,387	27.3
Brown	796	18.2	26.9	177,163	7,705	184,868	205,183	100	205,283	11.0
Buffalo	4,162	12.0	14.2	991,513	6,210	997,723	991,065	5,684	996,749	(.1)
Burt	1,849	21.0	14.4	367,918	10	367,928	376,988	4,467	381,455	3.7
Butler	1,792	19.2	19.1	390,081	53,729	443,810	378,149	100,811	478,960	7.9
Cass	2,601	12.8	12.3	593,748	12,169	605,917	640,533	16,846	657,379	8.5
Cedar	1,980	17.4	19.4	485,164	—	485,164	510,853	—	510,853	5.3
Chase	759	16.0	20.9	151,293	—	151,293	190,110	—	190,110	25.6
Cherry	997	14.8	10.8	216,614	—	216,614	171,927	—	171,927	(25.9)
Cheyenne	1,567	15.6	13.0	224,445	33,124	257,569	225,387	40,954	266,341	3.4
Clay	1,437	17.7	17.0	513,665	—	513,665	470,025	22,055	492,080	(4.4)
Colfax	2,030	20.5	16.3	410,575	22,847	433,422	456,327	9,142	465,469	7.4
Cuming	1,986	17.0	14.2	359,313	—	359,313	382,553	534	383,087	6.6
Custer	2,725	19.6	19.1	819,996	419	820,415	792,738	6,409	799,147	(2.6)
Dakota	1,712	10.3	12.6	433,517	17,183	450,700	422,437	17,274	439,711	(2.5)
Dawes	1,404	13.3	18.0	267,553	105,333	372,886	343,660	9,296	352,956	(5.6)
Dawson	3,116	14.0	12.7	773,009	11,706	784,715	761,987	19,144	781,131	(.4)
Deuel	530	21.5	8.5	75,482	—	75,482	72,895	—	72,895	(3.5)

Table 2 — Medicaid expenditures for long-term care of individuals who are aged 65 and older, by county, Nebraska, 1984 and 1985 (continued)

County	Population aged 65 and older			Medicaid expenditures for long term care[2]						Change[3]
				1984			1985			
	Quantity	Percentage of total	Percentage living in poverty	Intermediate care facilities	Skilled nursing	Total	Intermediate care facilities	Skilled nursing	Total	
	Number	— — Percent — —		— — — — Dollars — — — —			— — — — Dollars — — — —			Percent
Dixon	1,327	18.6	20.3	296,249		296,249	307,562		307,562	3.8
Dodge	5,418	15.1	12.0	1,130,526	390,698	1,521,224	1,157,964	294,160	1,452,124	(4.7)
Douglas	41,483	10.4	12.0	10,308,041	4,528,886	14,836,927	10,488,947	4,869,538	15,358,485	3.5
Dundy	593	20.7	19.0	95,540		95,540	119,062		119,062	24.6
Fillmore	1,573	19.9	14.6	316,242	5,705	321,947	326,889	21,816	348,705	8.3
Franklin	1,054	24.1	17.6	296,574	3,746	300,320	286,224	13,732	299,956	(.1)
Frontier	620	17.0	15.5	119,799	1,477	121,276	145,688	1,477	147,165	21.3
Furnas	1,627	25.1	16.6	346,213		346,213	386,821	2,432	389,253	12.4
Gage	4,432	18.1	14.1	1,071,746	74,036	1,145,782	1,129,988	107,467	1,237,455	8.0
Garden	619	22.1	10.0	173,234	2,861	176,095	187,894	440	188,334	6.9
Garfield	533	22.6	24.8	87,802	7,205	95,007	105,993	11,791	117,784	23.9
Gosper	347	16.2	18.7	82,800	—	82,800	98,982	—	98,982	19.5
Grant	119	13.6	11.8	6,314	4,797	11,111	6,715	—	6,715	(65.5)
Greeley	673	19.4	24.5	159,513	516	160,029	177,015	1,312	178,327	11.4
Hall	5,964	12.5	13.2	1,196,184	35,177	1,231,361	1,330,642	51,602	1,382,244	12.3
Hamilton	1,299	13.5	11.7	325,100	3,846	328,946	319,047	499	319,546	(2.9)
Harlan	920	21.4	17.6	246,532	20,534	267,066	282,325	34,154	316,479	18.5
Hayes	178	13.1	16.3	13,556	—	13,556	14,313	—	14,313	5.6
Hitchcock	752	18.4	13.3	169,083	—	169,083	175,814	—	175,814	3.9
Holt	2,083	15.4	21.5	630,898	—	630,898	666,399	1,629	668,028	5.9
Hooker	190	19.2	17.9	40,400	—	40,400	33,660	—	33,660	(20.0)
Howard	1,123	16.6	16.5	308,081	13,831	321,912	271,783	—	271,783	(18.4)
Jefferson	2,025	20.6	15.7	507,673	19,140	526,813	512,744	11,314	524,058	(.5)
Johnson	1,152	21.8	16.0	158,721	1,368	160,089	175,593	41.757	217,350	35.7
Kearney	1,179	19.5	12.0	225,363	10,962	236,325	220,680	35,326	256,006	8.3

Table 2 Medicaid expenditures for long-term care of individuals who are aged 65 and older, by county, Nebraska, 1984 and 1985 (continued)

County	Population aged 65 and older[1]			Medicaid expenditures for long-term care[2]						Change[3]
				1984			1985			
	Quantity	Percentage of total	Percentage living in poverty	Intermediate care facilities	Skilled nursing	Total	Intermediate care facilities	Skilled nursing	Total	
	Number	— — Percent — —		— — — — Dollars — — — —			— — — — Dollars — — — —			Percent
Keith	1,275	13.6	16.0	303,909	12,212	316,121	292,961	4,054	297,015	(6.4)
Keya Paha	205	15.8	15.6	27,654	—	27,654	40,396	—	40,396	46.1
Kimball	677	13.9	9.6	148,784	6,907	155,691	145,870	1,440	147,310	(5.7)
Knox	2,196	19.2	19.6	541,369	3,002	544,371	585,480	1,350	586,830	7.8
Lancaster	19,572	10.2	9.1	4,079,490	882,943	4,962,433	4,217,800	1,548,725	5,766,525	16.2
Lincoln	4,342	11.9	13.9	794,073	23,291	817,364	877,092	19,269	896,361	9.7
Logan	145	14.8	15.9	14,395	—	14,395	11,926	—	11,926	(20.7)
Loup	144	16.8	16.0	23,081	—	23,081	8,296	—	8,296	(178.2)
Madison	4,580	15.0	16.0	1,029,584	17,638	1,047,222	1,026,055	20,204	1,046,259	(.01)
McPherson	105	17.7	3.8	11,689	—	11,689	10,357	—	10,357	(12.9)
Merrick	1,406	16.1	12.1	404,424	1,045	405,469	402,485	52	402,537	(.7)
Morrill	1,037	17.0	17.5	291,359	—	291,359	283,459	—	283,459	(2.8)
Nance	886	18.7	23.4	191,363	—	191,363	184,714	—	184,714	(3.6)
Nemaha	1,539	18.4	19.7	411,687	16,690	428,377	461,624	8,435	470,059	9.7
Nuckolls	1,335	19.8	21.8	374,210	959	375,169	417,348	4,959	422,307	12.6
Otoe	2,943	19.4	13.3	748,063	67,756	815,819	852,086	100,460	952,546	16.8
Pawnee	977	24.8	20.8	220,785	8,471	229,256	248,199	16,190	264,309	15.3
Perkins	638	17.5	14.0	126,822	—	126,822	170,559	—	170,559	34.5
Phelps	1,744	17.9	13.6	268,983	—	268,983	279,558	—	279,558	3.9
Pierce	1,452	17.1	17.5	310,697	—	310,697	283,035	1,053	284,088	(8.6)
Platte	3,529	12.2	15.5	508,317	22,947	531,264	617,099	35,056	652,155	228.7
Polk	1,265	20.0	14.7	352,696	23,552	376,248	340,545	34,714	375,259	5.3
Red Willow	1,954	15.5	14.5	305,307	5,377	310,684	337,183	—	337,183	8.5
Richardson	2,536	22.4	18.5	638,639	31,418	670,057	701,831	51,646	753,477	12.4
Rock	396	16.6	11.1	74,069	15,103	89,172	98,631	16,477	115,108	29.1

Table 2 — Medicaid expenditures for long term care of individuals who are aged 65 and older, by county, Nebraska, 1984 and 1985 (continued)

County	Population aged 65 and older[1]			Medicaid expenditures for long term care[2]						Change[3]
				1984			1985			
	Quantity	Percentage of total	Percentage living in poverty	Intermediate care facilities	Skilled nursing	Total	Intermediate care facilities	Skilled nursing	Total	
	Number	— — Percent — —		— — — — Dollars — — — —			— — — — Dollars — — — —			Percent
Saline	2,612	19.9	13.3	584,591	13,236	597,827	624,408	10,915	635,323	6.3
Sarpy	2,909	3.5	6.3	627,113	227,309	854,422	662,154	256,884	919,038	7.6
Saunders	2,949	15.8	12.7	607,476	64,399	671,875	647,258	114,609	761,867	13.4
Scotts Bluff	4,989	13.0	14.8	1,056,893	92,074	1,148,967	1,102,714	63,673	1,166,387	1.5
Seward	2,215	14.0	13.4	493,985	31,026	525,011	562,894	50,581	613,475	16.8
Sheridan	1,290	17.1	19.5	297,126	2,601	299,727	307,311		307,311	2.5
Sherman	875	20.7	22.2	227,798		227,798	244,050	1,196	245,246	7.6
Sioux	254	13.8	14.6	29,212	8,326	37,538	30,154	662	30,816	(21.8)
Stanton	799	12.2	20.8	166,852		166,852	156,139		156,139	(6.9)
Thayer	1,665	22.0	15.4	499,358	706	500,064	515,044	5,886	520,930	4.2
Thomas	119	12.2	22.7	51,399		51,399	46,216		46,216	(11.2)
Thurston	965	13.4	22.6	221,152		221,152	194,766	4,292	199,058	(11.1)
Valley	1,158	21.0	20.4	205,910		205,910	198,105	15,001	213,106	3.5
Washington	1,366	13.9	12.1	326,480	43,264	369,744	407,962	42,972	45,934	21.9
Wayne	1,366	13.9	15.6	264,577		264,577	264,174	1,283	265,457	.3
Webster	1,131	23.3	24.2	329,681	15,470	345,151	388,015	29,860	417,875	21.1
Wheeler	136	12.8	14.0	24,453		24,453	23,298		23,298	(4.9)
York	2,241	15.1	12.7	458,941	11,543	470,484	495,291	12,578	507,869	7.9
Total	205,684	13.1	15.5	48,944,915	7,629,263	56,574,178	51,364,379	9,097,655	60,462,034	6.9

— = not available

[1]Population aged 65 and above by County, percentage of total population aged 65 and above, and percentage of those aged 65 and above whose income falls below the proverty line. Source: U.S. Census Data, 1980.

[2]Includes expenditures for intermediate care facilities for aged and disabled adults who are not mentally retarded and expenditures for skilled nursing facilities; does not include Medicaid expenditures on behalf of the aged for hospital, physician, dental, or prescription drug charges. Source: Statistical Section, Nebraska Department of Social Services.

[3]Values in parentheses indicate reduction in percentage change

Nebraska in 1984 and 1985. Percentage increases and decreases from 1984 to 1985 include costs for skilled nursing and intermediate care facilities that were paid through the Medicaid Program for adults who were not mentally retarded.

Presumably, there is a close relationship between poverty rate and Medicaid expenditures. It is difficult to project future expenditures for long-term care, lacking an accurate way to predict poverty, morbidity, and long-term care costs. Given these qualifications, however, Medicaid expenditures for long-term care in Nebraska increased by almost 7 percent in just 1 year, about twice the rate of inflation. Table 2 provides costs for long-term care only and excludes costs for physicians, hospitals, and medications.

The cost of institutional care will skyrocket during the forseeable future as the number of older persons increases. If the rate of growth of Medicaid expenditures for long-term care remains constant (6.9 percent for 1984-85), by the year 2000, the cost will be $164.5 million. Because the rate of growth of the older population is accelerating, this is probably an underestimate. So, a projection of growth over 15 years from $60.4 million to $164.5 million is most likely a conservative estimate. Hospital, physician, and medication costs will also increase proportionately.

Policy Choices

Seeing public expenditures for long-term care for the elderly triple over 15 years should give any policymaker pause, and it would be tempting to say that there are a number of easy solutions to this problem. However, several factors beyond the raw numbers make this issue even more complex.

First, out-migrants among the aged tend to be the most prosperous. The people who can afford to pay for long-term care can also afford to move to Sun City or Santa Barbara. So, in many Nebraska counties, there is some erosion among the well-to-do elderly. Obviously, this increases the proportion in poverty, not in numbers but in percentages.

Second, while cost-containment efforts for Medicaid expenditures within the state and the nation have been somewhat successful, there is a practical limit to such efforts. Many nursing homes are caught in a cost squeeze. Simply limiting the number of dollars per day that the state will

pay for long-term care may contain expenditures, but it does not contain costs. As the operators' costs for food, utilities, labor, and fringe benefits increase, the quality of care at some point must decrease, given a fixed level of resources. Most facilities now receive less per day for a Medicaid patient than for a private-pay resident, who then pays a hidden subsidy for those whose care is being paid for by the state. The goal in most nursing homes is to maximize the proportion of private-pay patients or at least to maintain a careful balance of public versus private-pay patients.

Too many Medicaid patients means red ink at the end of the year for long-term care facilities. As a result, Medicaid patients become increasingly difficult to place. Social workers at hospitals who try to place Medicaid patients tell us that in a city the size of Omaha there may be only one or two beds available to Medicaid patients on a given day. So, simply slapping a lid on what the state will pay, the traditional solution up to this point, will only work so long before the available facilities dry up. And, if the figures in tables 1 and 2 tell us anything, it is that Nebraska will have a shortage of beds in nursing homes during the next several decades.

Third, nursing home patients are sicker and, thus, more costly to care for than they used to be. Twenty years ago, it was not uncommon to find ICF patients who were not really in need of nursing care living in nursing homes, they just had a hard time making it at home. Regulation of the industry has all but eliminated this kind of patient, the inexpensive patient. Also, home health care and social service programs for the homebound elderly have been so effective that by the time service alternatives are exhausted, the frail older patient is generally very sick and care is expensive. Further, the effect of diagnostic-related groups (DRGs) and prospective-payment plans on hospitals is to move more patients from short hospital stays into nursing homes, rather than from longer hospital stays back to their homes. This also increases the case complexity and the cost of care in long-term care facilities.

One final wild card is the level of prosperity versus the level of poverty among the aged. The economic status of the elderly has improved yearly since 1949, to the point where the poverty rate for the aged is now lower than that of the general population nationally. Presumably, prosperous elderly individuals are better able to pay for their health care. However, the poverty rate in Nebraska for individuals who are 65 years old or older has not gone down as quickly as the national rate—it remains at 15.5

percent. And, because of the crisis in agriculture and declining land values, we must project an increase, not a decrease, in poverty among Nebraska's aged population, at least for the short run.

Taking these factors into account, and given the fact that there will be a major problem in financing long-term health care in the future, we see choices for the state's policymakers from among seven alternatives.

Pay the Price. Given the increasing level of need among the fastest growing group of citizens, Nebraska's leaders may inevitably have to dig deeper into the state's fiscal pocket and pay the price for more long-term care. Since 1984-85, the state has paid the counties' share of Medicaid payments (it had been a 60:20:20 division of costs among federal, state, and county dollars), so the state now pays 40 cents of each Medicaid dollar. Because the care of the frail aged will require a bigger slice of the pie, either the pie must be enlarged or someone else's share of the pie must be whittled down. In the long run, making no decision will result in the choice of this decision.

Lower the Level of Quality. It may be possible to squeeze the nursing home industry a little harder. Keeping the reimbursement rate constant and allowing no new construction lets inflation eat away at the provider's share year-by-year. Keep the lid on and see what happens. The net effect of this option is to increase the subsidy that private-pay nursing home patients already pay for their less prosperous companions. Eventually, it will also squeeze the better nursing homes out of the Medicaid market.

Increase Home Services. The kinds of services that are provided by the Nebraska Department on Aging, through its network of Area Agencies on Aging, are designed to provide alternatives to institutionalization and to keep older people independent and out of nursing homes as long as possible. To a certain point, it is cheaper to care for people in their homes than in institutions. Currently, the best coverage is provided for the services that are cheapest to deliver, for example, meal sites, information, and referrals. Homemaker and home health aide services, day care, and visiting nurses are more expensive. A major investment in such health services to keep older people at home, however, might pay genuine dividends in the future.

Allow Partial Medicaid Payments. Presently, older persons must become paupers to receive Medicaid. They must spend down to $1,500 in personal assets, plus burial insurance, and then Medicaid will pay 100 percent of their long-term care costs. Many older people pay for their

health care until their personal resources are exhausted, and then the state takes over. It is fraudulent to transfer assets—say, a house or land—to a child prior to going on Medicaid. However, the temptation to preserve assets for children is there, and we have no reliable way of estimating how often this happens. Splitting the cost of long-term care or using a graduated fee schedule might help to preserve the resources of both the family and the state.

Nursing Home Insurance. Private insurance carriers have been slow to enter the market for nursing home coverage because of a lack of actuarial projections as to cost and risk. Use of long-term care varies tremendously, and most people have no idea that their regular health insurance usually does not pay for more than 30 days of nursing home coverage. Medicare will pay for 100 days per individual.

The odds are as follows: the average older person has about a 50 percent chance of spending some time in a nursing home (McConnel, 1984), but the industry's traditional rule of thumb of a 2-year stay is deceptive. Nationally, the average stay is 60 days, because 44 percent of those who die in a nursing home die within 30 days after admission (Thorson, 1986). Thus, the average is pulled down by people who die shortly after arrival. The odds of a 2-year survival are 29 percent (Lewis, et al., 1985). However, we all know of people who have been living happily in long-term care facilities for 7-8 years. And, a year's stay in one of Nebraska's better homes can easily cost $21,000 (plus medications and doctor bills). Thus, the range and risk are tremendous.

This does not mean that a public-private cooperative exploration of insurance for long-term care is out of the question. Creative approaches, incentives for private carriers, partial payment of insurance from public resources, or a public subsidy of insurance against catastrophic costs (say, of longer than 150 days), might save the state's resources in the long run.

Price Competition. The present certificate of need process, designed to hold down costs, in effect restricts the supply of nursing homes, reduces the choices available to consumers, and assures that every home in the state stays full. Whoever heard of a nursing home going broke? Pulling down all barriers and allowing unlimited construction of long-term care facilities would, at least in theory, allow for price competition. The most efficient providers of the most attractive products would survive, the others would fall by the wayside.

Assistance for Families. It might make more sense to provide a family that is caring for a frail elder assistance, perhaps $300 per month, than to pay $800 per month (the rock-bottom charge in this state) for nursing home care. We know that families typically go to the end of their ropes and beyond before they take the final step of institutionalization. Why not provide them with more rope? Visiting nurse and home health care already provide assistance to families that are caring for a sick elder. Perhaps the state could pick up part of the cost of some of these services.

These efforts might also be expanded. Respite care might allow family members to continue caring for an elder awhile longer. Families that opt for nursing home care usually are exhausted physically and emotionally and have nowhere else to turn. Give them some help, keep the frail elders at home longer and save the state's resources.

Some of these options are, obviously, more feasible than others. Decisionmakers may find some politically unpalatable, others may be accomplished easily, but they may provide only minimal benefits. Federal rules and regulations might, in some cases, stand as barriers to creative experimentation. Overall, assisting individuals and families to help themselves probably has the greatest potential good for the population. And, we should remember that most older people lead independent lives and get along just fine without too much assistance. Finally, we must also realize that doing nothing is, in fact, making a decision.

In conclusion, long-term care for the frail elderly is a serious problem, but all is not bleak. If, as Churchill said, one measure of a society is how it cares for its elders, then our society would have to be judged as a good one. Increases in the older population will come steadily but gradually; we can see this coming, and we have time to do something about it. The most dramatic jump in the demographics will come in the year 2011, when the post-war babies become post-war senior citizens. Even then, the proportion of elderly people in Nebraska will be lower than the current percentage in most of the countries of Western Europe.

Old people of the future will be more prosperous, educated, and healthy. They are good citizens who vote, pay their taxes, and stay out of jail. Families are, and will continue to be, the greatest providers of care for their members. While those who are without families in later life have more problems, this is a small minority. Older Nebraskans have stability and resourcefulness. Policymakers with vision need not see the

aging of the population as a catastrophe. We have met the aging, and they are us.

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