

Financing Long-Term Care for the Elderly: Am I *Your* Parents' Keeper?

by Marshall B. Kapp, J.D., M.P.H.

Taken together, the articles in this issue of *Law, Medicine & Health Care* graphically illustrate that in the sphere of long-term care for the elderly, perhaps more than in any other aspect of health care delivery, society has tried to "have its cake and eat it too." It is time that we begin to make some difficult choices.

First, federal and state governments have pervasively regulated every aspect of the long-term care industry in the name of quality control and residents' rights. As the articles by Sandra Johnson and Timothy Jost make clear, the calls for even more extensive and restrictive regulation enjoy strong support from many who purport to advocate on behalf of nursing home residents. The costs of complying with and enforcing such regulations have not been determined with exactitude. It is safe to assume, on the basis of both our logic and experience, that fulfilling and enforcing legal quality control requirements in long-term care effectively and seriously does entail some level of extra financial expenditure.

Second, Elias Cohen's fine contribution in this issue discusses our commitment, in theory if not in implementation, to the constitutional and ethical right of the older individual to attain access to appropriate long-term care services in the environment that is the least restrictive of that person's claim to autonomy. If we heed Cohen's suggestion and create a meaningful continuum of long-term care services from which the older individual and his advocates may choose according to particular

Mr. Kapp is Associate Professor at Wright State University School of Medicine in Dayton, Ohio, and Associate Editor of Law, Medicine & Health Care.

preferences and needs, we can expect that here too the economic costs of long-term care will escalate.

Juxtaposed with the Johnson, Jost, and Cohen pieces is that of Norman Daniels,¹ which reminds us that, even as we call for reforms of long-term care that would inevitably involve the spending of more money in pursuit of quality and freedom, we still struggle—largely unsuccessfully—with the question of how to finance our current, deficient long-term care non-system. There exists a dissociation between, on one hand, our rhetoric and our regulation regarding rights both to and within long-term health care and, on the other hand, our willingness to decide upon and carry through with the means of adequately financing a system that provides those rights. Even the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research expressly evaded the opportunity to try to reconcile thinking about rights (benefits) and costs in the context of long-term care, although it did tackle this tension in other areas.² When looked at in concert, the ideas propounded in this issue of *Law, Medicine & Health Care* show how legally, ethically, and politically counterproductive and unacceptable is this evasion.

A reconciliation of our notions of quality control, freedom of choice, and long-term care financing may be achieved in a variety of ways, but the methodology awaits first a clarification of our underlying values. We must decide how much these benefits are worth to us before we can struggle with how to obtain the purchase money.

Potential mechanisms for financing long-term care for the elderly abound.³ The range encompasses the purely private market-place, filial re-

sponsibility requirements,⁴ comprehensive coverage through Social Health Maintenance Organizations (SHMOs),⁵ private long-term care insurance⁶ (which states could legally compel private health insurers to offer in conjunction with their other benefits),⁷ life or continuing care communities,⁸ more substantial funding of Medicare⁹ and Medicaid¹⁰ for long-term care, and new sources of government funding such as Title 21 of the Social Security Act or universal national health insurance. We can assign responsibility in any way that we choose to the individual, the family, the private sector, or the public.

No particular ideology or financing methodology is advocated in this editorial. Rather, what is urged is some long-absent direction and rationality in long-term care policy; this is a plea for ideological clarity, whatever the value scheme adopted. I may or may not be your parents' keeper. Either way, our principles and the choices—choices that must deal simultaneously with the forces of autonomy, quality, and cost—that carry out those principles, must be developed and made public. What is no longer tolerable is our current hypocritical demands for regulatorily enforced, unlimited long-term care quality and freedom without a corresponding willingness to arrange payment for the associated costs of those benefits.

References

1. Daniels has discussed this subject in other publications as well. See, e.g., Daniels, N., *Am I My Parents' Keeper?* in PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES (U.S. Gov't Printing Off., Washington, D.C.) (vol. 2: Appendices, Sociocultural and Philosophical Studies) (1983) at 265. The title of this edito-

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rial is, obviously, a parody of Daniels' title. See also N. DANIELS, *JUST HEALTH CARE* (Cambridge University Press, Cambridge, Eng.) (1985).

2. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES* (U.S. Gov't Printing Ofc., Washington, D.C.) (vol. 1: Report) (1983); Lynn, J., *Ethical Issues—Equitable Distribution and Decision Making*, in *LEGAL AND ETHICAL ASPECTS OF HEALTH CARE FOR THE ELDERLY*, M.B. Kapp, A.E. Doudera, H. Pies, eds. (Health Administration Press, Ann Arbor, Mich.) (1985—in press) [hereinafter referred to as *HEALTH CARE FOR THE ELDERLY*].

3. See generally Wallach, S.F., *Alternative Methods of Financing Long-Term Care*, in *HEALTH CARE FOR THE ELDERLY*, *supra* note 2.

4. See generally Callahan, D., *What Do Children Owe Elderly Parents?* *HASTINGS CENTER REPORT* 15(2): 32–37 (April, 1985). Cf. Kapp, M.B., *Residents of State Mental Institutions and Their Money (Or, the State Giveth and the State Taketh Away)*, *JOURNAL OF PSYCHIATRY AND LAW* 6(3): 287–356.

5. See generally Wallach, *supra* note 3; Greenberg, J., et al., *S/HMO: The Social/Health Maintenance Organization and Long Term Care*, *GENERATIONS* 9(4): 51–55 (Summer 1985).

6. See Guncheon, K.F.F. *Insurers Ironing Out Wrinkles in Long-Term Care Coverage*, *HOSPITALS* 58(14): 110–13 (July 16, 1984); Meiners, M., *Long Term Care Insurance*, *GENERATIONS* 9(4): 39–42 (Summer, 1985).

7. Cf. *Metropolitan Life Insurance Co. v. Massachusetts*, 53 U.S.L.W. 4616 (U.S. June 3, 1985) (empowering the state to require that minimum mental health benefits be provided to state residents insured under general health insurance policies or employee health care plans that cover hospital and surgical expenses).

8. See Leonard, L.R., *Comment: The Ties That Bind: Life Care Contracts and Nursing Homes*, *AMERICAN JOURNAL OF LAW & MEDICINE* 8(2): 153–173 (Summer, 1982), reprinted in *HEALTH CARE FOR THE ELDERLY*, *supra* note 2.

9. See Loeser, W.D., Dickstein, E.S., Schiavone, L.D., *Medicare Coverage in Nursing Homes—A Broken Promise*, *NEW ENGLAND JOURNAL OF MEDICINE* 304(6): 353–55 (February 5, 1981); Smits, H.L., Feder, J., Scanlon, W., *Medicare's Nursing Home Benefit: Variations in Interpretation*, *NEW ENGLAND JOURNAL OF MEDICINE* 307(14): 855–62 (September 30, 1982).

10. See Oday, L., *Medicare and Medicaid Update*, in *HEALTH CARE FOR THE ELDERLY*, *supra* note 2.

Cost Containment and Humanizing Medicine

Dear Editors,

I read with interest Marshall Kapp's book review essay in the April issue concerning the attorney's role in helping to humanize medicine. However, the medical profession is getting mixed messages from society in this era in which cost containment is a key goal, with physicians being told they are participants in a competitive industry in which traditional business precepts are to be followed. Convincing physicians to devote more time (for that is what a caring approach will require) in interacting with their patients is no small task. Who would relish accepting the responsibility to urge a physician to be more attentive, and listen more, to his patients, when the physician has been recently solicited to enter a Preferred Provider Arrangement, which will lower his revenue per item of service in order to maintain and, perhaps, to increase his patient population?

Nathan Hershey, LL.B.

Professor of Health Law
Graduate School of Public Health
University of Pittsburgh
Pittsburgh, Pennsylvania

Heart Transplantation in Massachusetts and the Prince of Denmark

Dear Editors:

A Shakespearean controversy has evolved between George Annas, Chairman of the Massachusetts Task Force on Organ Transplantation, and some Massachusetts health care providers. The Task Force, in its report published in the February issue, has opted for a Procrustean measure and has chosen to "restrict the total number of transplants" to fit the demands on health care financing in the state. Professor Annas, also in the February issue, says that his physician colleagues quote *Hamlet* in defense of transplantation: "Diseases desperate grown by desperate appliances are relieved or not at all." The Chairman's preference is for the King's earlier speech: "How dangerous is it that this man [organ transplantation] goes

loose! Yet must not we put the strong law on him. He's loved of the distracted multitude. . . ." (IV.iii).

Hamlet's fatal flaw was ambivalence. His quest for justice was marred by indecision. The Task Force choice for *propter hoc* limitation of heart transplantation is exemplary of the Hamlet Syndrome. The plan would fund an indicated health care intervention for only some of the time, and is a clear case of halfway decision making. This outcome derives from concern that transplantation is a halfway technology. It is also, according to Professor Annas, "extreme and expensive," and time is needed "to persuade the public that a free-for-all in organ transplantation is reckless, while a controlled system has pay-offs in terms of quality care, equity, and cost savings." The Report of the Massachusetts Task Force nonetheless acknowledges the relative success of heart transplants and renal transplants compared to other types of emerging transplantation technology. The expense of the Medicare-funded End-Stage Renal Disease program notwithstanding, renal transplantation represents only 10 percent of end-stage renal disease management and results in satisfactory levels of rehabilitation among a population for which death and dialysis are the alternatives.¹ Heart transplantation, a newer technology, has had increasing success, with Dr. Shumway's group reporting an estimated five-year survival in approximately two-thirds of cases.² Liver transplantation has been less effective but the results are encouraging with dramatic improvement in many cases.

One factor which beclouds the area of heart transplantation is the decision in 1980 by the trustees of Massachusetts General Hospital to abstain from heart transplantation. The decision, since reversed, was strongly influenced by a minority viewpoint among the clinical staff of the hospital that preventive health care measures were a priority in the health care system. The schism between proponents of primary preventive care and advocates of assertive tertiary intervention parallels the division between "old liberalism" and "new conserva-