Variations in Using Long Term-Care

The long-term care sector of the health care industry is fraught with inequalities of usage and availability due to characteristics such as gender, race, ethnicity and class. Long-term care refers to services for individuals who need support over an extended period of time. Typically patrons are women who have outlived their husbands and lack the social support to stay at home. The women currently using the system are a part of a generation that consisted of men as breadwinners and women as mothers, raising children but not producing much more expendable income. The husbands that passed may have had employee-based insurance, but in many cases these do not cover long-term care. Therefore, recipients of care will collect a large monetary burden due to the volume of time and resources utilized, but they will generally be unable to pay. The financial load then turns from the individual to the family or government. Relatives can be given more responsibility for actual care in an informal setting, providing the essentials for the disadvantaged or they can become the bill payer. Oftentimes both scenarios create a huge investment for those related to the person of need.

Organized care is also characterized by a white population more than any minority. The disparity may be due to cultural differences, but some have suggested that race may be an indication of access barriers for minorities. There seems to be a similarity in this regard in both the short-term care and long-term care settings. Minorities use less because of their view of need, combined with some discrimination throughout the health care industry.
Another more substantial indicator of an individual’s usage of long-term care services is their ability to pay. With a national occupancy rate of 95%, these facilities have the ability to pick and choose the populace they want to serve. Since most are for-profit organizations they seek higher returns and therefore higher profit margins. With Medicare and Medicaid providing only discounted rates for long-term care and a finite funded period for the individual there are incentives for companies to accept patrons that are willing and able to pay out of pocket. This clientele allows long-term care organizations to charge a full amount, increasing profitability. This can be viewed as discrimination, but with a smaller supply of organizations compared to the amount of service demanded, companies have the luxury of looking for clients that are willing to pay out of pocket. With an increase of supply as more and more companies enter this service sector there will be a subsequent decrease in the quantity demanded, at the same time driving down the charges. Increased supply would open the doors for more government funded individuals as more and more companies would try to stay competitive. This would not equalize the quality of care, but would improve access.

There are other alternatives to the cut and dry usage of long-term care services. Private sector initiatives have hoped to improve the funding for individuals needing long-term care through promotion of saving and through individuals pooling risks. Some argue that this still sharpens the divide between rich and poor. Informal care is still another option that is available for individuals with relatives willing to help. The government even provides funds for some of these individuals and their respite services along with the allowance of the Family and Medical Leave Act.

The growth of the older population is only going to put more strain on the system.
Long-Term Care in the United States

The health needs of the American population are currently in the process of shifting away from acute care and moving towards that of care for chronic disease. Pair that with the aging of the “baby boomer” generation and we have the current dilemma of long-term care for American citizens. With some estimates claiming that by 2035 one in five Americans will be sixty-five or over, there must be some restructuring of long-term care to balance the strains that the “baby boomer” population will put on the U.S. health care system. The central issue of the debate for long-term care reform is how a system can be designed so that adequate and high quality long-term care services can be provided equitably to the growing and diverse aging population.

Under our Current system, Medicare pays for the first one hundred days of post-hospital recovery care in a nursing home and provides no coverage for custodial care. Medicaid programs, on the other hand, pay for both custodial care as well as skilled nursing care and have become the primary funding source for nursing homes. Currently around forty percent of new patients to nursing homes enter as private paying patients spending out of pocket, however many patients become eligible for Medicaid after spending down their resources. With the population aging and the cost for medical care increasing, the current system of long-term care is in jeopardy.

Because current Medicaid reimbursement is lower than the amount nursing homes charge to private paying customers, nursing homes generally favor patients who can pay expenses out of pocket. In addition studies have shown that the quality of care for
Medicaid patients is especially poor when compared with that of self-paying patients. Without a change in health policy regarding long-term care administered in nursing homes, the gap between quality of health between self-paying and Medicaid paying patients will continue to widen.

Though not all patients require nursing homes to administer their long-term care, programs such as community-based care will also see a major strain on resources in the near future. Even though community-based services per individual is usually cheaper than that of a nursing home, total costs tend to be higher because usually more persons are served by community-based care than would have been served by nursing homes. Couple that with an aging population, and we will see a major dependence of resources for community-based care by seniors in the coming years.

Long-term care is an important topic that will become a cornerstone of politics in the coming years. With an aging population requiring more resources, long-term care must become a major issue on the political agenda. With the current model, seniors are required to spend down their savings in order to become eligible for government assistance to long-term care, leading to the quality of long term care becoming a function of a senior’s ability to pay out of pocket. This is in no way an equitable system. Politicians must address how the aging population will receive access to long-term care and how it will be funded. The limited financial resource of our aging population creates a need for a universal Medicare type of insurance for long-term care. However with social security reform being a hot topic in today’s political arena, it is tough to say if extended coverage by Medicare for long-term care will be a reality anytime soon.
As we know, men and women in the United States both need “affordable, accessible, and quality health care”. Unfortunately, there are discrepancies within the system as to why women, even though they tend to have a higher rate of use of health care services than men, have a harder struggle to obtain and finance their health care coverage. In “Changing the US Health Care System”, the authors discuss some of the underlying factors that can explain why women under the age of 65 become caught between the “gaps” of qualifying for health care coverage. Some of contributing factors for why women are least likely to have health care coverage stem from their lack of access to care, that they have a “less advantaged and less stable economic status”, their roles as a “coordinator of care” for their families results in less time available to seek their own care and the financial burden that one or all of these has on them.

The majority of Americans who have health care coverage receive insurance primarily through their employers or the employment of a spouse or parent. Others who also have health care coverage obtain it from individually purchased private insurance, Medicaid or Medicare programs. Although the numbers of women working full-time is on the rise, they are less likely than men to have independent employment-based coverage. This is due to the fact that most of the women are covered by their spouse or parent’s employment-based coverage. In addition, some women work part-time or seasonally usually making them ineligible health care benefits.

In comparison, women are “twice as likely as men to be covered by Medicaid because of eligibility and income requirements”. Ironically, there are many low-income women who do not qualify for such governmental assistance programs. For those who do qualify, their coverage varies across ethnical diversity lines. Studies show ethnic and black minority women are less
likely than white women to have independent or dependent employment-based coverage, more likely to qualify and receive Medicare and are more likely to be uninsured. In general, low-income women have higher rates of uninsured.

Chapter one in this book also discusses the inequitable reality of access of care and coverage to minority and low-income populations. Table 1.1 suggests that there was a decline in the mid 1980’s through late 90’s in private health insurance plans and a rise in Medicaid to both the white-non Hispanic and minority populations (except for Mexican population due to their high rates of immigration). However, trends in “insurance coverage according to income level since 1984 generally suggests an increase inequality”.

Other contributing factors that affect women’s health care coverage involves changes in the both the private and public health coverage. Employers are now trying to sway employees to take an employee-only coverage. However, one criticism of this is that this leads towards managed care plans and/or higher health care costs for family coverage. Medicaid especially is “vulnerable to economic constraints” and has been moving from a fee-for-service to a managed care plan. People are concerned that managed care plans negatively affect quality and access creating more barriers for women and low-income families. In addition, access to services tends to hinder many women from obtaining a continuity of care due to lack of continuous health care coverage.

Nonetheless, we also have to note that just because one has insurance still does not mean that they can afford the co-pays, deductibles and co-insurance more insurance plans require. Thus, this increases the financial risk even for the insured women. The book also states that women because of OBGYN care are more likely than men to use physician services. However, uninsured women are less likely to see a physician on a regular basis. It is this lack of continuous health insurance that results in women typically receiving services that may not need or may receive repeated services. It is apparent that the equalities exist not only among whites compared to minorities, but also they are disparities between access and health care coverage among the sexes in the United States.
Health reform in this country has not only had widespread effects, but has specifically changed health care delivery for many specialty populations. The system of care for children and families has especially gained attention as its organizational development has evolved. It has become apparently difficult to balance the moral obligation to provide adequate and available care to children, while still meeting financial obligations to profit the health care industry. This conflict of interest may be compromising the existing system’s effectiveness and adding to the increasing numbers of children who lack insurance and have several barriers to receiving appropriate care.

Children are considered a special population due to their unique developmental issues, different patterns of morbidity and mortality and their dependency on guardians for care. As with any population, financial determinates remain the major barrier to care. Andersen states that two-thirds of uninsured children live in families with income above poverty level (and not eligible for Medicaid). Even those children who receive Medicaid assistance face access issues as many reimbursement rates remain low and various eligibility rules prevent specialty services. Cost sharing has become a barrier to care, as well, because many families cannot afford even minimal cost sharing fees. Barriers other than financial issues can also have an effect on access to care. Racial or cultural barriers, lack of provider training, and lack of providers (especially in rural, poor locations) may prevent many children from receiving adequate preventative care.
The ultimate goal of health reform for children should include the provision of comprehensive, continuous, coordinated and accountable care. Unfortunately, this goal is not easily achieved, particularly when the current system is fragmented and lacks coordination. This creates delivery deficits that contribute to the unavailability and low quality of some children’s health care services. Different approaches have been proposed to reform the current system’s organization, which includes three separate child health sectors. One example of a model used in California to coordinate health services is a mental health initiative that organizes efforts from varied disciplines including health, juvenile justice, mental health, and education agencies. This approach seems to expand level of care both vertically and horizontally.

If a similar model was implemented to coordinate children’s health care there may be potential concerns for volume overload or financial constraints. Health policy makers must struggle with these possible solutions and potential outcomes before endorsing an organizational change. The need to provide better care for our children certainly has great support, but finding the funds to finance such an effort is a different story. As managed care organizations try to standardize and control medical services for children, children who are atypical (who may suffer from chronic diseases, or may have special social circumstances) may be denied care. There may need to be a safety net created for children who seem to fall through the cracks. Unfortunately, with such large numbers of uninsured children, it remains difficult to determine which children are worthy of being included in the “safety net”. Which services should be provided? How could quality of care be improved? Which risk factors should be targeted? Creating a health care system
tailored to the specific needs of children is certainly a complex, but necessary task toward saving and improving innocent lives.
In chapter twelve of the text “Changing the US Health Care System” the authors discuss a number of the concerns and shortcomings of the US mental and behavioral health care system and offer recommendations for improvement. This paper will discuss certain special populations faced with issues of great concern as related to mental health care.

The text identifies a number of populations that are particularly vulnerable when it comes to the receipt of adequate mental health services. The elderly, though their rates of mental disorder appear to be similar to those of younger adults, are less likely to be diagnosed and treated for mental illness. They are also less likely to receive specialty mental health services due to the fact that many providers are unable to distinguish their disability from the normal aging process. The much higher prevalence of Alzheimer’s disease and other dementias place additional financial and emotional burden on patients and their caregivers.

Children between the ages of nine and seventeen form another population of concern. This concern is due to the fact that diagnosis of mental illness among children is more difficult than among other populations since it relies heavily on the word of “proxy respondents” like parents or teachers. Other difficult issues among this population include inadequate access to specialty care due to a shortage of providers specializing in
children’s mental health issues and doubt about the safety and efficacy of mental health medications for children.

Minorities and rural residents also face challenges with regards to the need for and access to mental health services. Some minority groups harbor feelings of “distrust of the system” while others face language barriers that can affect the quality of care provided. Rural residents often have limited access to mental health specialists and frequently must travel longer distances to receive care, thus incurring greater time and transportation costs.

The text discusses in some detail the need for maintaining some public mental health facilities to act as a safety net for those patients with severe illness who are unable to function and care for themselves. Though this issue is important I believe that the issue of access for those with less-severe, acute mental disorders is just as, if not more important. Private insurance plans do not adequately cover mental health services, adversely affecting the health and economic status of this population. I believe that until legislation mandating the adoption of more comprehensive mental health services by private insurance companies is put in place this problem will continue.
Millions of Americans are diagnosed each year with some type of mental health disorder. It is estimated that 21% of the United States overall population suffers from a diagnosable mental disorder. Mental illnesses are not associated with high mortality rates but often do create life-altering disabilities that can limit an individual’s day-to-day capabilities and spark social concerns such as violence, abuse, and instability. In recent years, the overall treatment costs for mental disorders in the U.S. has reached as much as $82 billion per year or approximately 8 percent of the total yearly health care costs. With these astonishing figures surrounding mental health treatment in our society, mental health disorders should be classified as a leading health concern in the U.S. thus: (1) establishing the need for separate services (apart from general medical intervention), (2) creating the need for revision of existing policies concerning insurance coverage, treatment, and education of mental illnesses, and (3) recognizing the barriers to proper care and working to diminish them as well as the associated stigma.

Mental health disorders are defined as “conditions characterized by alterations in thinking, mood, or behavior associated with distress and/or impaired functioning.” Examples include anxiety and mood disorders, schizophrenia, and dementia. Mental health services are delivered in four separate sectors: the specialty sector (psychiatrists), the general medical sector (primary care physicians), the human services sector (social welfare programs), and the voluntary support network sector (support groups). Diagnosis and treatment of mental illness can take place in hospitals, community mental health clinics, physician’s offices, and residential treatment facilities. Treatment options fall into two categories: psychosocial counseling or pharmacological treatment.
Mental health professionals, such as psychologists, psychiatrists, and clinical social workers are trained to properly interact with mentally ill patients, whereas a primary care physician is familiar with mental disorders but not specifically trained in successful treatment interventions. General physicians primarily focus on prescribing of potent, and often times expensive, psychotropic medications. Mental health professionals provide more appropriate care using their area(s) of expertise. The three leading factors as to why individuals seek mental health services from general practitioners rather than specialists are: stigma of using a mental health professional, insurance plans include mental health services in a primary care visit, and an inadequate supply of mental health professionals throughout the U.S.

Insurance plans must recognize that quality mental health services are essential in proper overall treatment of its insurees. Medicaid, currently the leading source of public mental health funds with approximately 53% of expenditures, must continue to provide mental health benefits to beneficiaries and possibly expand coverage. Private parties account for approximately 47% of mental health coverage, including private insurance, out-of-pocket expense, and other private funds. Private insurers need a policy mandating that mental health care NOT be treated under a general office visit with a primary care physician, thus opening the doorway to enhanced mental health coverage. Barriers to care can be decreased by assistance from all involved parties, including the patient, professionals, caregivers, family members, etc.

Since mental illnesses have been determined to be a high ranking factor in disability-adjusted life-years, second only to cardiovascular conditions, and the Surgeon General has identified the need to overcome the stigma associated with mental health as the most important step in improving care, it is time that Americans demand high quality mental health services and policy makers consider the demands and re-analyze existing mental health care policies to better accommodate society.
The State of Child Health Services

The United States faces many problems in its attempt to coordinate child health services. It seems as though funds are poured into child programs from numerous agencies and organizations, but children are still unable to access adequate, beneficial services. While it is important to understand why children need these services, it is also important to know why they are unable to utilize them, and what is being done in an effort to improve these services.

There is a direct correlation between a lack of insurance and a decrease in the health of a child. Uninsured children are less likely to see a doctor for routine visits, ailments, and injuries. Due to their lack of primary care utilization, uninsured children are often seen in the emergency room or in hospital outpatient departments. This shift from one family doctor to a number of emergency room or urgent care providers has been found to alter the health of children in a negative way. A child who has a regular doctor is more likely to be diagnosed easier simply because that provider knows the child’s history and is more perceptive to the child’s symptoms. Likewise, an insured child diagnosed with a certain illness will receive treatment for that illness by their family or primary care provider. Uninsured children, on the other hand, often change providers and have to undergo altered treatment procedures, causing long term consequences. This is especially true of the newly discovered child morbidities, which stem from family background and socioeconomic status: drug and alcohol use, family and neighborhood violence, emotional disorders, and learning problems. Early detection of these problems and consistent treatment are crucial to a child’s development. For example, a child with an emotional disorder who is forced to change psychologists frequently will benefit less from visits and is likely to be apathetic to suggestions made by doctors.

Because the government understands that problems exists in child health, they have tried to ensure that all children have access to health care through state and federally funded programs such as Medicaid, SCHIP, and various other community health programs. With so many programs and agencies contributing funds for the healthcare of children, one might assumed that almost every child in the country has access to
health services. Such is not the case, however, since many of these programs were implemented as quick fixes to up-and-coming problems by agencies with little coordination. Though numerous programs are in place, many children still lack health care coverage. In 1992, 56.2% of children were insured by one or more parent through an employer. This was a drop from 60.7% in 1987. Many of these children were subsequently covered by Medicaid, whose numbers increased 54% between the years of 1989-1993.

Reasons for the lack of child health coverage is due in part to the inability of working parents to either afford insurance premiums or qualify for these benefits, which are often not offered to employees in the service sector. Surprisingly, 74% of uninsured children live in families where one or both parents are employed.

While the government has been trying to break down the financial barriers to child health care, both the private and government sectors have been trying to improve the quality of care that children receive. Medicaid surveys are sent out annually by state child health programs to measure the quality of services and accessibility. The Child and Adolescent Health Measurement Initiative (CAHMI), a group formed by the Foundation for Accountability (FACCT) and the NCQA (along with other federal agencies), was developed in 1999 to set quality standards for children. In fact, the NCQA, HEDIS, and CAHPS (the Consumer Assessment of Health Plans) have all tried to capture the status of child healthcare. Unfortunately, it is difficult to complete such a task given the unique nature of child health. Children are constantly changing, creating varied measurements that are difficult to use when predicting future outcomes and ways to handle them. Because children are less likely to have chronic or long-term illnesses, it is a challenge to compare them based on the quality of an inpatient stay or an outpatient surgical procedure.

It is imperative that the status of the child health service be more organized and coordinated in order to ensure that children have the best possible developmental potential. The institution of SCHIP programs and coverage by Medicaid services has attempted to coordinate child healthcare, but the authors appear to neglect this fact and the importance of these programs. Some states (including Kentucky) have gone as far as developing their CHIP to cover all children under the age of 18, given that they meet minimal requirements. As a result, many working parents are opting not to purchase coverage for their children. This causes one to question the quality of privately insured services if parents are so willing to switch to an SCHIP program.