GUAM HEALTH PLANNING AND DEVELOPMENT AGENCY

LONG-TERM CARE PLAN

LONG-TERM CARE PLAN

Technical Report No. 86-04

Prepared by: Ulla-Katrina Craig, Chief Planner
Approved by: John Onedera, Acting Administrator

TABLE OF CONTENTS

		Page
I.	LONG-TERM CARE	1
II.	LONG-TERM CARE IN THE NATIONAL PERSPECTIVE	2
	A. Core Services	4
	B. Community Facilities or Services	4
	C. In-Home Services	4
	D. Services either in the Home or an Institution	5
	E. Institutional Care	5
III.	LONG-TERM CARE ON GUAM	7
	A. Increase in the Senior Population	7
	B. Incidence of Chronic and Disabling Conditions	8
	C. Changes in Culture and Values	8
	D. The Existing Long-Term Care Services	9
IV.	SERVICES GAPS IN THE LONG-TERM CARE CONTINUUM	16
	A. Senior Day Care	16
	B. Family Foster Care for Seniors	17
	C. Incentive Pay Program	18
	D. Respite Care	18
	E. Hospice Care	18
V.	FINANCING OF GUAM'S LONG-TERM CARE	20
VI.	PROPOSED MODEL OF LONG-TERM CARE	25
	A. System's Design	25
	B. Financial Issues	29
VII.	CONCLUSION	32
	BIBLIOGRAPHY	33

I. LONG-TERM CARE

Long-term care refers to a continuum of interrelated health and social services. This encompasses both institutional and non-institutional services and requires coordination of public policies, funding, and case management to provide appropriate options for services to individuals whose needs inevitably change over time. Long-term care is intended to provide the individual users with choices among a variety of services, used singly or in combination, that will minimize the disabilities of chronic disease or debility, support as independent a lifestyle as is practical, and prevent further complication of chronic health conditions.

Long-term care is not just for the elderly; it is needed by anyone of any age who is unable to cope with the tasks of daily living without assistance for an extended period of time because of physical or mental impairment. This might even include some developmentally disabled children and adolescents, disabled adults, and the chronically mentally ill. The key is functional dependency, not age.

Long-term care services should be geared toward helping the recipients successfully master the activities required for daily living while improving their personal satisfaction and the quality of their lives. Furthermore, long-term care in its broadest interpretation should also encompass the education and training of providers of services, the preventive services that help avert chronic illness, and the basic research that seeks to circumvent the illnesses so often associated with later years.

Long-term care and services can be provided in a facility, in a community setting, or brought into the home. Sometimes services move from one setting to another, or overlap. The various kinds of institutional, community, and home services are detailed in the following sections.

II. LONG-TERM CARE IN THE NATIONAL PERSPECTIVE

The increasing number of older people, the lengthening of lifespan, changes in the family composition, the growth of the female labor force, and political and economic conditions have made long-term care an urgent concern of health care providers and policy makers in the United States. Expenses for long-term care have risen dramatically since Medicare and Medicaid became involved in the financing of long-term care services, particularly in institutional care. Over the last 10 years, the costs for such care have increased more than three-fold, reflecting both the number of people served and demand for services, as well as the cost per service unit.

A disproportionate share of health care resources are consumed by the elderly. Although they comprised only 11 percent of the population in 1978, 29 percent of the health care dollar was spent for their care. Additionally, the elderly tend to utilize more costly health services than the younger population. Hospital expenditures make up 43 percent of health care expenditures for this age group.

National expenditures for nursing home care reached $27 billion in 1982, about six times the amount spent in 1970, and up from $24 billion in 1981--an increase of 13 percent in one year. Almost 50 percent of the $27 billion were covered by Medicaid and Medicare, with private insurance only paying for about $200 million--1 percent of the total. This left an amount of $12 billion to be paid by the elderly and their families for long-term care. The U.S. Congressional Budget Office had projected that national expenditures for long-term care would reach between $63.7 to 74.5 billion in 1985.

The population aged 65 and older has doubled in size, rising from 12.4 million in 1950 to 24.9 million in 1980. By the year 2000 the older population is expected to number 35 million, comprising approximately 13 percent of the total population.

TABLE 1

U.S. Population Aged 65 Years and Over: Selected Years and Projections, 1950-2033

Year	Number in Thousands	Percent of U.S. Population
1950	12,397	8.1
1970	20,087	9.9
1980	24,927	11.2
2000	34,899	13.0

Source: Facts About Older Americans, U.S. Bureau of the Census, 1983.

Not only have the relative numbers of persons 65 years and older increased steadily since 1950, the distribution within the aged population has shifted towards the older ages. The most dramatic growth will occur in the age cohort that is 75 and over. This "old" old population is projected to increase four times faster than the population under 65, expanding from 39 percent of the total elderly population in 1980 to 50 percent by the year 2000. Those over 85 will more than double between 1980 to 2000 to 5.1 million.

While aging in itself is not a disease, normal aging involves a general decline in the functioning of all the body's systems, making the elderly more susceptible to chronic illness. About 80 percent of the older population suffers from one or more chronic diseases or debilities, necessitating medical care and social support to varying degrees--e.g., they require long-term care services.

For many years, long-term care has been synonymous with skilled nursing institutional or nursing home care. Such care has proven to be extremely expensive, is considered inappropriate in many cases, as well as unsatisfactory to those in need. The problems of cost and quality of institutionalization have received considerable exposure in discussions of long-term care and have fostered a growing demand for "alternatives." However, there is some danger in the use of the word alternative, as it seems to demand a clear-cut "either/or" division between institutional care and all other health or social resources needed in a community. There is growing consensus that a responsive and comprehensive community-based system of long-term care

is required which provides a number of options to those who need assistance to remain at least semi-independent, and that the institutional bed should be available when needed, but not called upon unless it is in the client's best interest to do so.

An ideal system of long-term care, frequently also referred to as a continuum of comprehensive care, should have the following array of services and programs:

A. Core Services

These services should provide information, referral, outreach, multi-disciplinary assessment and case management, and should enable a needy person to obtain the prescription for services in the form of a services plan that best respond to his total needs.

B. Community Facilities or Services

Such services allow a person to stay in his own home yet allow him to partake of community resources within his own limitations. Community services include:

Congregate Housing (Group living with minimal supervision)
Adult Senior Day Care (Social and Medical Models)
Senior Recreation Centers
Congregate Meals
Transportation Services
Senior Employment Services
Public Health and/or Housing Assistance

C. In-Home Services

Home care services are delivered to an individual at at his residence. It assumes a degree of frailty that prevents regular participation in programs outside the home. Such services encompass the following:

Visiting Home Care Nurses
Homemakers and Health Aides
Homebound Meals (Meals on Wheels)
Transportation to medical appointments
Friendly Visiting
Telephone Assurance
Escort Services
Foster Care

D. Services either in the Home or an Institution

Respite Care
Foster Care
Hospice Care

E. Institutional Care

Acute Hospital Care (ACF)
Skilled Nursing Facilities (SNF)
Intermediate Care Facilities (ICF)
Supervised Residential Facilities (SRF)
Sheltered Housing
Board and Care Homes

The above services illustrate the range of potentials in the delivery of long-term care services. Most of these services or programs are available in the urban areas, and some of them in the rural communities. The programs and services are funded and administered by diverse agencies, differentiating between social services and health-related services.

In planning for community-based services for the disabled, frail, or chronically ill, two trends prevalent in attitudes have been identified. The one is a desire to define clearly "health-related" services, e.g. medical care services which can be reimbursed by Medicare, Medicaid, the HMOs and third-party payers. The other is a growing concern for the large number of disabled and frail persons for whom life in the community becomes impossible when access to health care and the capacity for self-care are restricted because of decreasing mobility and an inability to perform certain of the activities required for daily living. For these persons a comprehensive social support system becomes a necessity.

Since health care and social services are funded, and consequently managed, by different entities, there is usually a lack of coordination, which results in either an overlap of services, or the underserving or non-serving of needed clients. In addition, there are varying eligibility criteria for the services: some are entitlements, free of charge to the elderly of a certain age, others require that the recipient belong to a low income group. As a consequence, the older person in need does not have equal access to particular services and therefore does not have the opportunity to choose among them.

These problems have been recognized by local, state, and federal governments and have led to a redefinition of long-term care and appropriate service alternatives. Cost-containment provides the major impetus for innovative programs. However, a more efficient mode of delivery and improved quality of care for long-term care services are expected outcomes of new delivery models.

The issue of financing long-term care is a subject receiving considerable attention by policy makers and advocates for the elderly. It is generally acknowledged that any solution must involve both government programs and the private insurance industry. Moreover, the ability of individuals and their families to provide a portion of the revenues needed for long-term care should also be assessed.

Several bills have been introduced to Congress to support appropriate alternatives to institutionalized care. The bills propose that Medicaid and Medicare monies for health care should be augmented with Title III monies from the Older Americans Act for needed social services, and that all services to seniors should be provided by a single agency. Such agencies would be charged with outreach, information, case management and the supervision and the evaluation of services, assuring quality care in the most appropriate setting to support an individual's independence as long as possible.

III. LONG-TERM CARE ON GUAM

Guam has followed the national long-term care issues and efforts with great interest, since a crisis has arisen in the health care system pertaining to the provision of long-term care services to the island's seniors. A steady expansion of the number of aged, a higher than national incidence of chronic and disabling diseases, a change in culture and values, and the move from the extended to the more nuclear family have contributed to the crisis, which is compounded by the growing number of females in the formal labor force. All these factors have led to an inappropriate provision of care for a number of Guam's elderly.

A. Increase in the Senior Population

Guam has experienced a steady population growth since the turn of the century. With this came an increase in the older population; however, only in the last decades were there a sizable number of aged, and this number is rapidly expanding, as can be seen in Table 2.

TABLE 2

Increase In Senior Population
Aged 65 and Older
Guam: 1920-1980

Year	Total Population	Senior Population	Percent
1920	13,275	290	2.2
1930	18,509	468	2.6
1940	22,290	675	3.0
*1950	59,498	798	1.3
1960	67,044	1,088	1.6
1970	84,996	1,480	1.8
1980	105,979	2,938	2.8
**1985	121,844	3,423	2.8
**1990	138,606	5,219	3.8

*A large influx of U.S. military and civil service personnel as well as alien laborers occurred after the war and still comprises approx. Twenty to Twenty-five percent of the total population.

**Figures are projected, using the 3.1 percent growth rate experienced from 1970 to 1980.

Sources: U.S. Bureau of the Census, Guam Bureau of Planning, Guam Health Planning and Development Agency.

As illustrated above, in 1980 there were only 2,938 persons aged 65 or older. This proportion increased to 3,423 in 1985, and the numbers are expected to rise further to 5,219 persons in 1990, almost double the number counted in 1980.

B. Incidence of Chronic and Disabling Conditions

The physical and cognitive infirmities expected with and often experienced in old age brought about a sharp increase in consumers for a health services delivery system which has made no formal provision for long-term care. This situation is exacerbated by Guam's high incidence and prevalence of diabetes, hypertension, heart disease and neurological diseases (particularly amyotrophic lateral sclerosis and Parkinson's dementia) with all the attending complications of these diseases, such as amputation, blindness, stroke, congestive heart failure, and partial or total paralysis.

C. Changes in Culture and Values

Guam's society has changed from extended, close-knit families to more nuclear ones. Some elders live now alone while their children reside off-island; others have outlived their children. And some of the seniors who came here in their younger years from the U.S. mainland, the Philippines, or from other Asian countries, never established any families on island. In those instances where an older relative lives with his family, it is quite possible that all mature members are working, leaving the older person on his own during the day. As long as the elder is able-bodied, able to care for himself, and contributes to the family by babysitting or performing chores, he is a welcome addition to the family. But if he becomes sick or mentally incompetent and needs constant care and supervision, family conflicts arise, since one household member, usually a female, has to forego work and earnings in order to care for the relative. Most families cannot afford this loss of income, since all their combined financial resources are required to meet mortgage and loan payments and to provide for their children's education. A choice has to be made: either a family adheres to the old and time-honored custom of taking care of their own kin and therewith sacrifices income; or the family wants to partake of the higher living standard marked by higher education for their children and material acquisitions, which requires multiple

incomes, and relinquishes their frail and feeble relatives to the care of the community. The aged parent, grandparent, or other relative becomes a burden, a drain on the family resources, and an impediment to personal freedom, since the caregiver(s) must at all times attend the frail relative. In such cases admittance to the old Guam Memorial Hospital seems the only solution to the dilemma.

D. The Existing Long-Term Care Services

The following tabulation gives evidence that the seniors of Guam enjoy a number of services brought into existence mostly through the influx of federal monies.

Services or Programs:	Available
Core Services:	
Information & Referral (Senior Service)	Yes
Outreach (Senior Service)	Yes-limited
Case Management (Senior Service)	Yes-limited
Community Facilities or Services:	
Retirement Housing for Seniors	Yes-limited
Residential Living (for mentally retarded)	Yes-limited
Senior Recreation Centers	Yes
Transportation for Seniors	Yes
Senior Day Care	No
Congregate Meals	Yes
Senior Employment Services for Seniors	Yes
Legal Services	Yes-limited
In-Home Services:	
Visiting Home Care Nurses	Yes-limited
Homemakers/Health Aides (Senior Service)	Yes-limited
Homebound Meals	Yes
Companion/Escort/Friendly Visits	Yes-limited
In-Home or Institutional Support Services:	
Senior Foster Care	No
Respite Care	No
Hospice Care	No

Services or Programs, continued:	Available
Institutional Services:	
Acute Care	Yes
Skilled Nursing Facility	Yes
Intermediate Facility	Yes
Supervised Residential Facility	No
Sheltered Housing	No
Board and Care (nursing or convalescent) Homes	No
Other Support Services:	
Supplemental Social Security	No
Old Age Cash Assistance	Some
Foodstamps	Yes
Housing Assistance	Yes
Medicare/Medically Indigent Program (MIP)	Yes

1. Core Services:

   Core services consisting of Outreach, Information and Referral, as well as Case Management, are furnished by the Division of Senior Citizens (DSC) under the Older Americans Act and are primarily concerned with the coordination of other Title III programs and the public assistance programs provided by the Guam Department of Public Health and Social Services (DPHSS).

   Case management is required for persons who can no longer take care of their own affairs and who need assistance in obtaining social or medical benefits. Case management makes referrals to appropriate agencies or programs and follows up on such referrals. Catholic Social Services is contracted by the Division of Senior Citizens to provide case management to Guam's seniors.

2. Community Facilities or Services:

   Those services in general favor the more able-bodied and ambulatory seniors on Guam. Most of the services are provided through the federal Older Americans Act, Titles III and IV, which are administered by the DPHSS' Division of Senior Services (DSS).

The Division provides all administrative functions for the services as well as the Information and Referral Program for Seniors. The other direct services are contracted to providers in the community.

(a) The Guam Housing and Urban Renewal Agency (GHURA) is providing housing assistance to needy seniors and disabled persons through their Section 8 program. Guma Trankilidad, a housing project especially designed and built for able-bodied seniors, is also administered by GHURA. Similiar housing arrangements are planned for the different island regions, with some of them already under construction.

(b) Guma Mami, a non-profit organization, provides supervised residential living to 8 mentally retarded adults in a group home in Barrigada. The home gives individuals an opportunity to live in a normal and healthy environment and enables them to develop their potential to be productive, and to be "mainstreamed" into the community.

(c) SPIMA (Servicio Para I Manamko) is a services subsidiary of GARP (Guam Association of Retired Persons) which operates the 16 Senior Centers around the island, and provides transportation to Guam's elderly and handicapped person in specially designed mini-Vans which can accommodate wheelchairs.

(d) General Enterprises prepares meals to be eaten in a congregate setting (the Senior Centers) and also for the homebound clients.

(e) For able-bodied seniors still willing to work, the federally funded Senior Community Services Employment Program (SCSEP) provides employment training opportunities for persons in need of income. The program is designed to equip seniors with the necessary skills to compete in the job market, to earn a living, and to retain their independence.

(f) Guam Legal Services gives legal aid for non-criminal matters to the island's seniors.

3. In-Home Services:

Home health care is provided by the home care nurses of the DPHSS' Community Health and Nursing Services. Registered nurses, licensed practical nurses, and nurses' aides visit bed-ridden patients in their home and tend to their medical needs.

The Home Care Program is locally funded and is reimbursed for services rendered by Medicare, Medicaid, and private insurance companies. Services are provided to anyone who meet the following criteria:

(a) The patient must have a suitable home environment;

(b) The patient must have someone living with him to assume the responsibility of taking care of him;

(c) The patient must be under the care of a licensed physician who must request for home care services;

(d) The patient must be under the continuous care of the physician so that current medical orders can be maintained.

Once the patient meets the criteria mentioned above, the following services are provided:

(a) Nursing Care Services (medical plan for care, treatment, medication, and diet);

(b) Nurse Aide Services (such as bathing, personal care services);

(c) Social Services;

(d) Coordination of all health care and social services such as occupational therapy, physical therapy, and hospital services if necessary.

Patients receive an average of three visits per week.

FHP Inc. and Health Maintenance Life (HML), both HMOs, also offer home nursing services to FHP subscribers in need of such services.

The Home Care Nurses are supported in their efforts by the Homemaker/Health Aide services. This is another Title III service under the Older Americans Act, contracted to Catholic Social Services

by DPHSS-DSS. Services provided include housekeeping tasks, shopping, meal preparation, and personal care services. Priority is given to clients who live alone. The program employs 14 homemakers/health aides under the supervision of two registered nurses.

Homebound meals are delivered to bed-ridden and frail elderly who are unable to cook for themselves. General Enterprises prepares and delivers 10,714 meals to approximately 500 persons in their home.

The recently established Interfaith Volunteer Caregivers program has been established to provide friendly visiting and escort services to the frail and disabled. This pilot-program is funded by the Robert Wood-Johnson Foundation and relies on volunteers from each religious denomination in the community. The program promotes the social and emotional well-being of shut-in and isolated persons through regular visits, or provides a few hours of respite for the regular care giver.

4. In-Home or Institutional Support Services:

   Those services are missing on Guam and are discussed in the section on services gap.

5. Institutional Services:

   All available institutional care is provided by the Guam Memorial Hospital. Acute care is provided in the new hospital. The Skilled Nursing Facility and Intermediate Care Facility are located in the old hospital, at the 5th and 6th floor respectively. There are 35 beds reserved for SNF level care, and 36 beds for intermediate and custodial care.

   Prior to the construction of the St. Dominic Senior Care Home, there was no organized nursing home on Guam. The 5th and 6th floors of the old GMH assumed this function on an informal basis, since it is the only place where the island's old, frail, handicapped, or mentally incompetent people are cared for. There is usually a 100 percent occupancy rate and patients spill over from one floor to the other, and sometimes into the new hospital. This makes for

inappropriate placement at the different care levels. Nevertheless, there is a long waiting list for people to enter the ICF, and in an emergency the hospital has always accommodated those who can no longer live alone and have no one to care for them.

At present, neither the SNF nor the ICF are accredited by the JCAH due to the many structural deficiencies of the old building. The Guam Memorial Hospital Authority, in order to gain accreditation for the new (acute care) hospital, has been released from the responsibility for the old hospital through Executive Order No. 84-2 in February 1984, which now charges the Department of Administration with the management and upkeep of the old facility.

Furthermore, the same Executive Order transferred responsibility for the intermediate and custodial care services (e.g. services for all persons below the level of skilled nursing care) to the Department of Public Health and Social Services. However, as this department has no history of providing direct services for this particular population, Guam Memorial Hospital provides all appropriate services under a management agreement and bills DPHSS for the rendered services.

There are several problems with Guam's institutional long-term care. The old building in which the services are housed is inadequate for patient care. For this reason the GMHA is finalizing plans to move the Skilled Nursing Facility to the new hospital within the next year. This will leave intermediate and custodial care patients in the top floor of a building which has so many deficiencies that it cannot meet licensing requirements for a nursing home without extensive renovation. Negotiations are under way to relocate these patients to the St. Dominic Senior Care Home once it is in operation.

Secondly, a number of the patients residing in the old hospital are inappropriately placed there and are not in need of the 24-hour professional nursing care provided at GMH-ICF.

Thirdly, and this is a most important factor, the majority of the patients currently placed at GMH-ICF have no relative and no significant social or economic resources, and have therefore become dependent upon the community at large.

In general, the need for long-term care beds is established by the number of people aged 55 and older in a community. A ratio of 8 beds to 1,000 persons in that age group is considered acceptable for supervised residential care and/or intermediate nursing care. Using the 1985 figures of 9,677, Guam's bed needs are calculated at 78.

If we pattern ourselves after Hawaii, which utilizes a ratio of 35 beds to 1,000 persons aged 65 and older, 120 beds would be required for Guam's 3,423 persons in this age group.

Since Guam's senior and health services providers feel that the island's elderly should be cared for at home as long as possible, the Guam Memorial Hospital's capacity for Skilled Nursing Care (35 beds) and St. Dominic's capacity for intermediate and supervised residential care (60 beds) should be sufficient for the next two years.

6. Other Support Services:

Those needy elderly or disabled persons unable to work are assisted by DPHSS through the Foodstamp program, Old Age Assistance or Aid to the Permanently and Totally Disabled cash payments, and the Medicare or Medically Indigent Program.

IV. SERVICES GAPS IN THE LONG-TERM CARE CONTINUUM

The previous section has examined the long-term care services provided to Guam's handicapped people and frail elderly. It was established that institutional long-term care at the intermediate and custodial level is inadequate as to setting as well as availability, since there is a long waiting list for admission to the present ICF.

In the next 5 years, the demand for such services will rise sharply, since the number of persons 65 years and older is expected to increase from 3,423 in 1985 to 5,219 in 1990. A much greater demand for institutionalized care will be noted. However, institutionalization should take place only as the last resort. Every effort should be made to retain a person at home in his familiar surroundings as long as possible.

Other communities, on the U.S. mainland and abroad, when faced with the same problems of caring for an invalid relative, have ameliorated them by implementing services that are designed to help a family with the care of such a relative while allowing family members to work, or by providing a family for a single older person unable to live alone. Those particular services are Senior or Adult Day Care, Foster Care, Respite Care, and Hospice Care. Additionally, cash incentives are being offered to families, and in-home services have been increased to provide support to families willing to care for their relatives at home.

A. Senior Day Care

Senior day care centers have been in existence in the mainland United States and the European countries for many years and enjoy great success. Such centers provide a level of care for senior citizens, who, although no longer capable of remaining in their home environment unattended, are not yet in need of 24-hour institutionalization. A day care center permits a person to spend a therapeutically structured day, while at the same time allowing him to remain within the community as long as possible. Responsibility for the elderly in the evenings and during weekends would remain with the family, thus preserving close family ties and preventing institutionalization.

Such a day care center would:

1. Provide a five-day program of care for the elderly during the general working hours of the week.
2. Provide medical attention for the clients.
3. Provide elementary nursing services.
4. Provide a nutritious diet.
5. Provide physical/occupational therapy as needed.
6. Provide recreation and stimuli to ward off depression and senility.

The senior day care center should be manned by a professional staff, including a social worker who will assist the client to secure financial aid and support services when needed. Furthermore, the social worker should help clients to resolve family problems, to alleviate separation anxiety and guilt feelings on the family's part, as well as generate and maintain family involvement of the client with the day care center's program.

In some senior day care centers, physicians and therapists provide services on a consulting basis.

Senior day care has been contemplated by Guam's care providers for many years. Several studies have shown that such care is needed, is appropriate, and would be acceptable to the Guam residents. The lack of a suitable facility and funding for the day care center operations have prevented senior day care from becoming a reality.

B. Family Foster Care for Seniors

Family foster care provides frail elderly and handicapped individuals an alternative to ICF or nursing home care by placing individuals in family settings. Usually, appropriate social and medical support services are provided as a component of the program.

Foster families are recruited from the community and are extensively screened for suitability. All families found acceptable must successfully complete the family care training. The training covers practical aspects of caring for a handicapped or elderly person at home, including personal

hygiene, bladder training and incontinence care, skin care, exercise, special diets, nutrition, and medication. An extensive Family Care Manual is provided during training and can be used for further reference.

All clients and foster families are visited by a nurse and social worker within a week of placement in a home. Thereafter, at least monthly home visits are completed. These home visits aid in the adjustment of the client and the foster family and to provide indicated linkages to community and medical services.

In most communities, the monthly foster family payment varies between $400 to $750. The exact rate is determined individually for each client by the staff nurse and social worker based upon the amount of assistance and supervision needed. After retaining forty dollars for the client's personal expenses, the remainder of the payment goes to the foster family.

C. Incentive Pay Program

This program would function similar to the Foster care Program, but the caregivers of the frail or disabled persons would be relatives who elect to quit work or stay unemployed in order to take care of the relative. Training and supervision would be the same as in the Foster Care Program.

D. Respite Care

Respite care offers short-time relief from patient care, ranging from a few hours to several days, to families and caregivers. This relief may avoid or delay institutionalization of the cared for patient, and can ameliorate caregiver problems resulting from the constant strain of caring for a sick or disabled person. Respite care can either be provided in the home by a person temporarily moving in, or a facility which is organized to provide such services.

On Guam, such services will be particularly helpful to those people who need to travel off-island for medical or family reason, and who have no one to look after the patient in their care during their absence.

E. Hospice Care

The concept of hospice care for the terminally ill is relatively new, but has found great acceptance in a short time in Europe and the United States.

Hospice involves the skilled and compassionate care of the dying and their families. Hospice is a program rather than a facility. It can function as a home care program or as a department in a hospital. The program is designed to give a patient a choice as to his place of dying. If he wants to die at home, then the support services of a multi-disciplinary team of physician, nurses, social workers, and hospice volunteers will help the patient and his family to do so. Should the care at home become too difficult, then the patient can be moved to the hospital, with the same multi-disciplinary team following him.

Hospice programs seek to accomplish four goals for dying people: relief from pain as much as possible, the security of a caring environment, sustained expert care, and the assurance that they and their families won't be abandoned at the end. Family members as well as the dying individual are considered the "patient." Care extends through the mourning period.

Guamanian families draw together and support each other when one of their members dies. Rituals have been established over the centuries that are comforting to the bereaved and ease their mourning. However, there are now many non-Guamanians residing on island, many of them without family support. For these persons, a hospice program becomes a necessity, and a less costly alternative to hospitalization. As Medicare now pays for hospice services, Guam's health care providers are exploring the feasibility of adding hospice care to the island's long-term care continuum.

The above services have two main factors in common: they prevent early and inappropriate institutionalization and they cost considerably less than institutional services.

V. FINANCING OF GUAM'S LONG-TERM CARE

Long-term care is costly care. High costs are incurred by a population with proportionally small incomes. A crisis in the financing of long-term care has developed in the United States due to an increase in the number of the aged and an increase in longevity. People live longer, have more chronic diseases, and need more care.

In the mainland, institutional long-term care is primarily financed by private individuals, Medicare, SSI (Supplemental Security Income) and Medicaid. Very few private health insurance companies cover long-term care in excess of certain stipulated days at a skilled nursing facility.

Long-term nursing care in the home is increasingly covered by Medicare, Medicaid, HMOs and other third-party insurers as it has proven to be a cost-effective alternative to hospital care. Other in-home services, such as the Homemaker/Health Aide program, are being financed by Title XX funds and Title III, Sections B and C of the Older Americans Act.

Senior or adult day care is an optional service provided under waivers from Medicare, Medicaid or Title XIX and augmented with local finances, for "medical" model senior day care centers. Title XX monies are used for social models. Title IIIB monies for nutrition are frequently combined with the above funds.

Foster care for seniors is financed through the Title XIX and XX appropriations with local supplements.

Community-based long-term care social support services are mostly provided through the Titles III and V monies of the Older Americans Act, sometimes augmented by local funds, or are financed by philanthrophic foundations.

Hospice care is reimbursed under a special provision of Medicare since 1983. Some HMOs and other third-party payers have added such care to their benefits package.

On Guam, funding for long-term care services and programs are derived from the various federal agencies, with the local government providing the required "match" in either dollars or "in kind." A list of services and their funding sources are presented as follows:

Service or Program:	Financed by:
Core Services:	
Outreach, Information & Referral	Title III-B (OAA)
Case Management	Title III-B (OAA)
Community Facilities or Services:	
Retirement Housing	GHURA (HUD)
Residential Living	Guma Mami, Inc., Gov. of Guam Funds, Territorial Lottery
Senior Centers	Title III-B (OAA)
Senior Employment (SCSEP)	Title V
Congregate Meals	Title III-C (OAA)
Transportation	Title III-B (OAA)
Legal Services	Title III-B/GovGuam
Supplementary Social Assistance	Federal and GovGuam funding
In-Home Services:	
Home Nursing Care	Medicare, Medicaid, CHAMPUS, Insurers, Gov-Guam General Fund
Homemaker/Health Aides for Seniors	Title III-B (OAA)
Homemaker/Health Aides for the Disabled	Title XX (SSA)
Homebound Meals	Title III-C (OAA)
Companion/Escort/Friendly Visits	Robert Wood-Johnson Foundation
Institutional Services:	
Acute Care	Insurers, Medicare,
Skilled Nursing Care	Medicaid, MIP
Intermediate Care/Custodial Care	Limited Self-Pay, Gov-Guam General Funds

Due to the large influx of federal monies, mostly the Title III monies of the Older Americans Act, community social support services are available to all of Guam's elderly. In-home services are provided, but the paucity of funding has restricted development of home nursing care as well as the homemaker/health aide services, and the existing demand is much greater than the available supply.

The financing of institutional long-term care is a major problem for individuals, families, and the community at large. No federal support-monies are available for any care below the SNF level. Medicaid under Title XIX and Supplemental Social Security funds are used in the U.S. mainland to provide supervised residential care and intermediate nursing care for the physically and mentally disabled and frail. Guam receives neither Medicaid nor SSI monies for these purposes.

The Guam Memorial Hospital has functioned as Guam's unofficial nursing home, providing services not only to those requiring intermediate nursing care, but also custodial care for persons who either had no one to care for them or whose families were unable or unwilling to retain and care for them at home. As a consequence, many of the patients at the ICF are inappropriately placed, and the facility is usually fully occupied, with vacancies occurring only upon the deaths of patients. At times the hospital had to place some ICF patients into the SNF because of overflow.

These services were paid for by subsidies from the Government of Guam's General Fund. Approximately $700,000 were spent yearly for care at the ICF. Since the government has assumed payment for this care it became easy for families to shirk their responsibilities: either of giving care themselves, or paying for the care at the ICF. The Audit Report by the Inspector General of the Department of Interior of February 1983 addresses these problems. It also mentioned that Guam Memorial Hospital has neither determined nor fixed financial responsibility for ICF bills of patients with adult offspring or guardians who are legally responsible for the debts of their parents or wards, and has never instigated legal action against families or guardians to pay for the bills. And of course, there are patients in the ICF who have no family and lack the financial assets to pay. All of these have contributed to a general belief that care at the ICF is "free."

This changed in 1984 when the Administrator of the Guam Memorial Hospital stated that he would no longer request any subsidy from the Government of Guam General Fund, and that therefore he could no longer provide "free" care to the Medically Indigent and those patients receiving care at the ICF on the 6th floor of the hospital. He referred to Guam's Public Law 15-139, the Senior Citizen's Act of 1978, and in particular Section 9988(e), which

states that one of the primary functions of the then created Division of Senior Citizens (under DPHSS) is "--- to plan, oversee, coordinate, or implement programs and activities for health care (of the elderly) including but not limited to the medical, health, and social services and special homes for the aged."

As a consequence of this, Executive Order 84-2 of February 1984 assigned responsibility for the patients of the ICF to the Department of Public Health and Social Services.

This action was also in concurrance with the recommendation of the Inspector General of the Department of the Interior, made after the above mentioned audit. He stated:

> "We recommend that the Governor of Guam direct the Department of Public Health and Social Services to comply with the provisions of the Senior Citizens Act of 1978, specifically as they relate to the implementation of the program for health care including medical, health and social services, and special homes for the aged."

An independent consulting firm, Bob Curry Associates from Washington D.C., that was contracted by the Division of Senior Citizens to investigate the feasibility of Senior Day Care, recommended that the Division of Senior Citizens should take over the management of the ICF, in order to consolidate all senior services.

Finally, the Long Range Institutional Plan of the Guam Memorial Hospital also stipulates the transfer of responsibility for the ICF to the DPHSS-Division of Senior Citizens.

With this transfer, the hospital hopes to solve two major problems: the elimination of uncollectable hospital fees for the care of the frail and feeble, and equally important, to regain JCAH accreditation which was lost largely due to the many structural and safety deficiencies identified during the accreditation visit of the Joint Commission on Accreditation of Hospitals. As GMH plans to move its Skilled Nursing Facility to the new hospital, and since the ICF has been transferred to DPHSS, large obstacles to accreditation will have been removed.

Since the Department of Public Health has no staff or facility to provide direct institutional care to the ICF patients, the Guam Memorial Hospital continues to provide appropriate care to the patients on the 6th floor to ensure their well-being. However, DPHSS is expected to pay for these services.

VI. PROPOSED MODEL OF LONG-TERM CARE

Guam has a considerable number of physically and mentally disabled persons, as well as an increasing number of frail and feeble elderly who require supervision and care. For some persons, institutionalization is necessary. However, for the majority of the disabled and frail, a community-based system of long-term care providing coordinated, comprehensive quality services would support their wish to remain in their own home as long as possible.

Guam already has a large array of community services. There are, however, important gaps which prevent a continuum of care, and there is a general lack of coordination between the health care and social support services.

A. System's Design

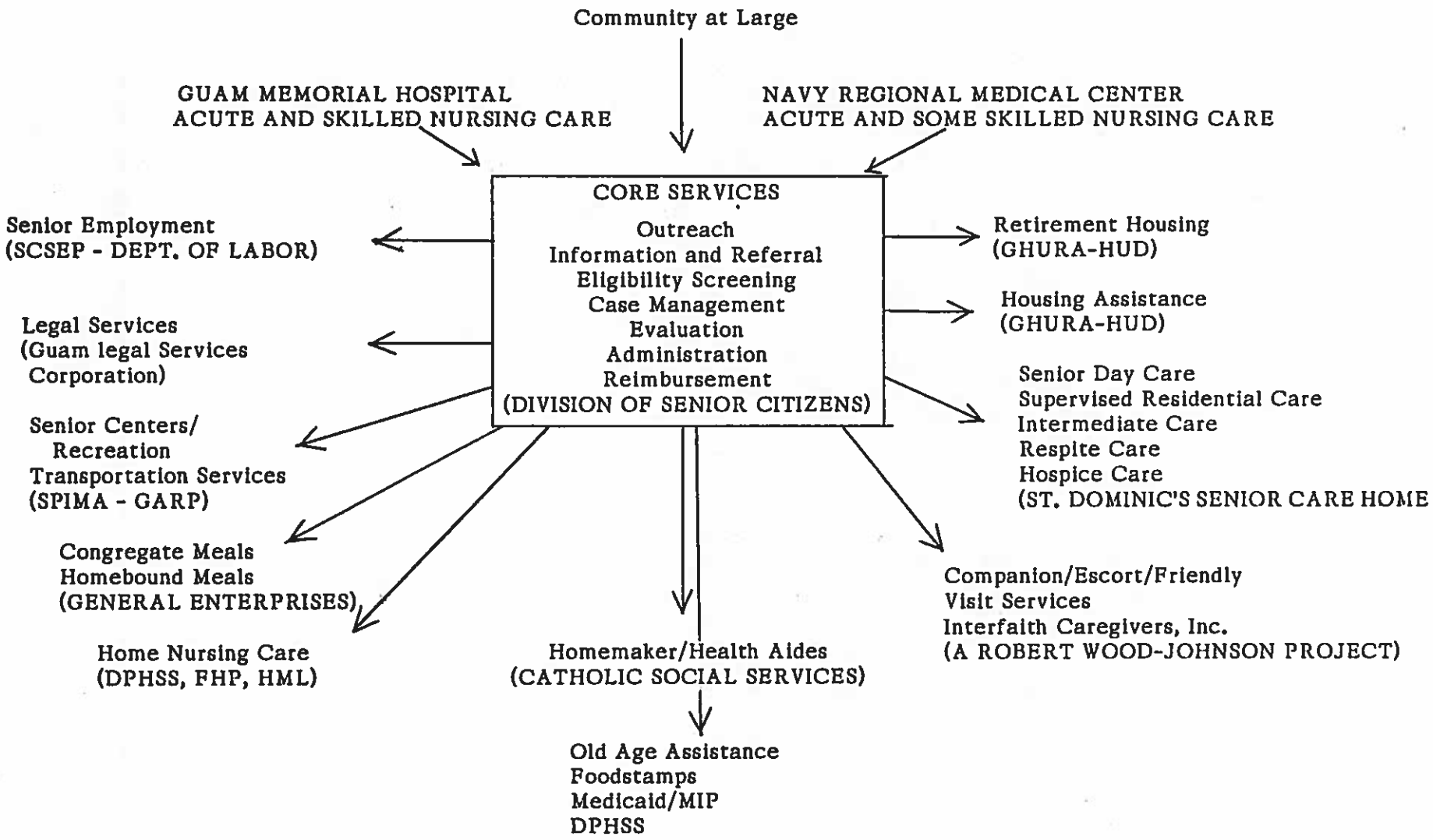
A comprehensive long-term care system to serve Guam's disabled persons and senior population should provide:

1. Core services administered by the Division of Senior Citizens, which will provide outreach, information and referral, case management and evaluation.
2. A range of alternatives between the hospital and supervised residential care, including home health care, senior day care, foster care, incentive pay to families, and respite care.
3. A sufficient number of SNF and ICF beds.
4. Supervised residential facilities for those who lack families and can no longer stay alone in their own home.
5. Innovative and compassionate ways of caring for the terminally ill outside of the traditional hospital.

The core services should be designed as the "gate" to long-term care. An inter-disciplinary case management team comprised of a registered nurse, social worker, and para-professional outreach, information and referral workers should investigate and assess individual persons as to their needs and arrange for all necessary services - health care as well as social support - to be provided at the appropriate level. Monitoring of care, the evaluation of progress and the quality of the delivered services will also be the responsibility of the case management team. (See Figure 1).

FIGURE 1

PROPOSED MODEL FOR GUAM'S COMMUNITY-BASED SYSTEM OF LONG-TERM CARE



The proposed core services are intended to eliminate the duplication of services, particularly the intake services of the various agencies now involved with the care of the elderly. At present, a senior in need has to undergo individual, highly bureaucratized, intake and eligibility screening for 1) welfare payments of Old Age Assistance; 2) food stamps; 3) Medicaid; or 4) MIP (Medically Indigent Program); 5) Housing Assistance; and 6) Senior Services. Very few of the elderly or handicapped persons possess the required stamina and necessary persistence to undergo these time-consuming and often humiliating procedures in order to improve the quality of their lives. Some give up in resignation.

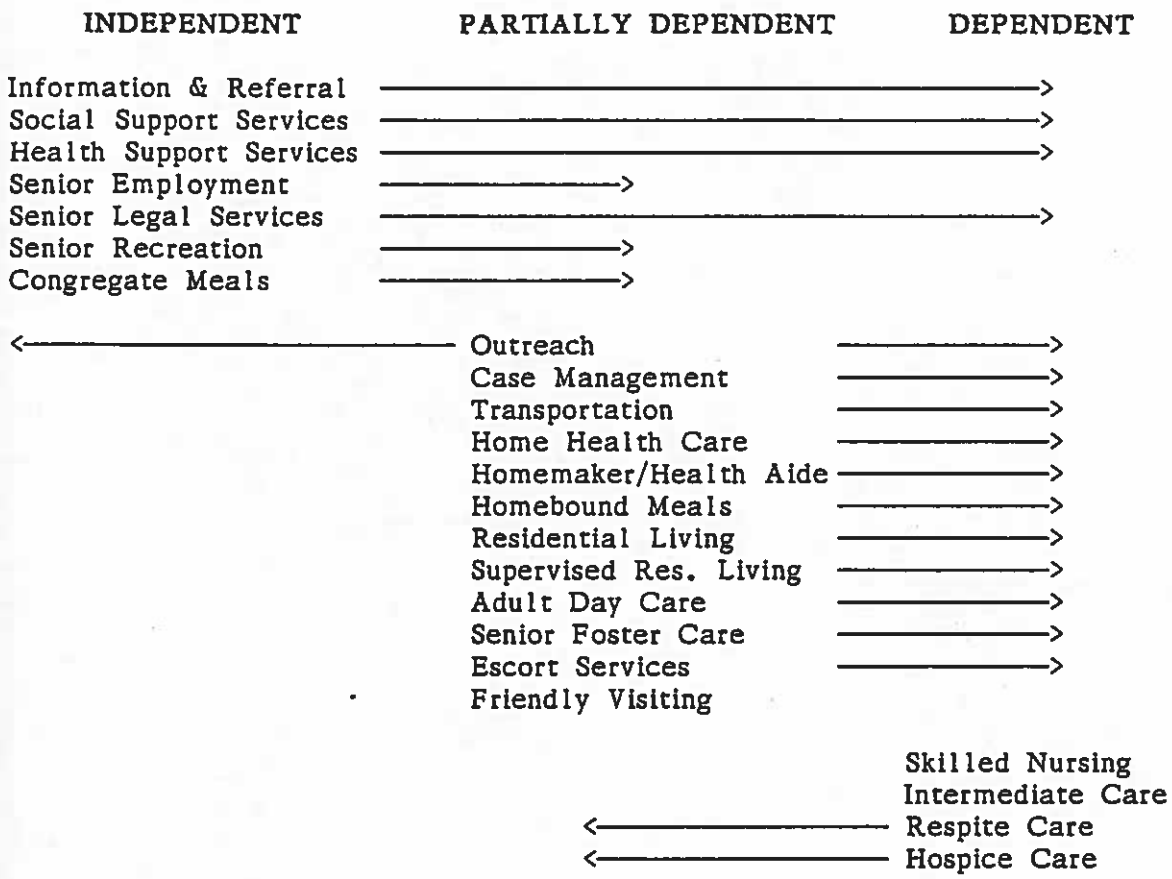
By having one centrally-located core program, the considerable overlap of tasks can be eliminated and intake provided in a more cost-effective manner which would also present much easier access to services by those in need. The current intake and eligibility workers at the various agencies can be relocated to the core services program.

The core services will also be responsible for the establishment of a care plan for each client accepted into the services. The care plan will be drawn up by an inter-disciplinary care team consisting of professional health care personnel and social workers, which will also be responsible for the monitoring and evaluation of care given to each client.

The proposed community-based long-term care system should serve all handicapped persons and frail seniors regardless of their level of dependence; services must accommodate a needy person from one level to another without any service interruption. The relationship between services is detailed as follows:

FIGURE 2

COMMUNITY-BASED CONTINUUM OF LONG-TERM CARE



The community-based services for able-bodied seniors are at present sufficient though there is a lack of retirement housing.

In-home social support services and home health care have certain criteria for acceptance to the programs, the main one being that a patient must be certified by a physician as being in need of such care. Lack of financial resources does not present an access barrier to those in-home services for any Guam senior; however, the current programs are understaffed and cannot meet the existing demand for home care nursing and in-home support services.

The institutional long-term services present major problems at this time. There is full agreement among the health services providers and Guam's policy makers that the old Guam Memorial Hospital is no longer a fit place for patient care. However, two anticipated developments will provide at least partial solutions within the next two years.

Guam has received from the Department of the Interior a grant in the amount of $5.4 million for the renovation and correction of structural deficiencies of the new hospital. The main projects to be completed under this funding are: addition of laundry facilities and dietary services (both services are currently contracted out to private companies in the community), renovation of the administrative wing, enlargement of the medical records section, enclosure of the exposed staircases and replacement of an unsafe elevator. Also planned is the relocation of the Skilled Nursing Facility, of the new hospital and an eventual increase of 20 beds. These renovations are expected to be completed in early Spring 1987.

In addition, the Religious Missionary Sisters of St. Dominic have filed for and received a Certificate of Need to build the St. Dominic's Senior Care Home with totally private funding received from Rome and Taiwan. This facility will be able to accommodate the frail and disabled persons currently located on the 6th floor in the old hospital more appropriately either at the ICF level or in the Supervised Residential Facility. There will be 60 beds available to be used in "swing-bed" fashion, and the Sisters will also be able to provide respite care, hospice care and senior day care in the same facility, which is designed to JCHA and HCFA specifications. the project is expected to open its door in early 1987 to the needy seniors of Guam.

Providing new and more appropriate facilities will ease access to needed care, but will not eliminate the financial issues and problems connected with long-term care.

B. Financial Issues

The preferred solution to the financial problem would be the lifting of the on Guam imposed ceiling for Medicaid and allow instead a federal share calculated on Guam's per capita income. This would allocate to Guam more than an additional $1 million, which, besides improving primary care services, would also help pay for patients in need of ICF or SRF level care. Both the Health Care Finance Administration and the U.S. Congress have been petitioned for such an increase, but real and tangible

results (rather than promises) can probably not be expected until Guam goes into final negotiation for the change in status from that of a Territory to either a Commonwealth or Free Association, both of which are expected to provide greater independence from U.S. federal regulations.

In the absence of federal monies, there are still some mechanisms that can be employed to ease the present situation. A feasible solution would combine and consolidate all available funding for the seniors and make the Division of Senior Citizens responsible for reimbursement for all services rendered to the seniors. Such funding would be the Title III and V monies received under the Older Americans Act (approx. $2.2 million), monies under the Titles XIX and XX under the Social Security Act, housing assistance provided to the seniors with HUD monies and other funds from the various categorical programs. These "pooled" funds should then be augmented by the approximate $700,000 from the Government of Guam General Fund which was formerly given to the hospital for the care of the indigent elderly, and which can be used to purchase ICF and SRF, as well as respite care, hospice care and senior day care from the Dominican Sisters at a lesser rate than required by the hospital to maintain the people on the 6th floor, and in a much more appropriate setting.

The Division of Senior Citizens would continue to contract for services in the community and reimburse for such services out of the same pool. The only exemption to this would be the funding received by the Interfaith Volunteer Caregivers, as the Robert Wood-Johnson Foundations has awarded the 3-year demonstration project to the Coalition of Guam Churches.

A source of revenues that has as yet not been fully investigated is the Veteran's Administration. As the V.A. on Guam only provides in-patient acute care and ambulatory out-patient care to the veterans at the Naval Hospital on Guam, all social services needed by them are provided by the community. Reimbursement mechanisms, particularly for home nursing care, senior day care, ICF and SRF level care, respite and hospice care need to be negotiated for and established, as the only alternative to veterans in need of such care is going to Tripler Hospital in Hawaii or to one of the Veteran's hospitals on the mainland.

The needy seniors themselves and their families need also be considered as a source of income for long-term care. Often the elderly "divest" themselves of all real and cash property in order to become "indigent" and eligible for medical care and social support services. Sometimes their children have them declared "incompetent" and will so become the legal guardians of the older persons, and the recipient of property and any cash income, such as Social Security or Veteran's pensions, rent from property, etc. Although the hospital requires that a person being admitted for long-term care (or, as it is in most instance, final care) signs over all property and cash income to the hospital for that care, this is not done in most cases. Nor has the existing Public Law established under the Guam Civil Code, Section 206, which holds adult offspring responsible for the care of their aged parents, ever been enforced. Until very recently, no legal action has ever been brought against the children or guardians of those persons residing in the old hospital.

VII. CONCLUSION

Guam's long-term care services need improving; they need to be combined so the existing array of programs and services can be welded together into a comprehensive continuum of care which will furnish services to those in need at levels best suited to them while maintaining independence as long as possible.

Establishing core services under one umbrella agency charged with the coordination, regulation and reimbursement of long-term care services, including health care as well as social services, will minimize fragmentation and duplication.

While it would be ideal if Medicaid funding for Guam could be increased, the existing financial resources for the elderly can be pooled and more efficiently managed, thereby providing better and more appropriate services to a larger number of people. As local and federal resources for health care will soon no longer be able to meet a rising demand, individuals and their families must be encouraged to assume greater responsibility, both by providing care when needed and contributing to the financing of it. Only through the shared functions of federal and local governments and individuals and their families can a comprehensive long-term system become the reality by which quality services are provided equitably to every person in need.

BIBLIOGRAPHY

Abel-Smith, B. "The History of Medical Care" in A. Crichton, ed., Health Policy Making, Health Administration Press, Ann Arbor, Mich., 1981.

Achenbaum, W.A., "Americans in an Aging Society": Myths and Images," Daedalus (115:1, Winter 1986.

Alford R. "The Political Economy of Health Care" in D. Mechanic, ed., Readings in Medical Sociology, Free Press, New York, N.Y. 1980.

Alpha Center Monograph: "State Initiatives in Long-Term Care," Office of Health Planning, U.S. DHHS, Bethesda, MD, 1984.

Alpha Center Monograph: "The Expanding Role of the Hospital in Providing Long-Term Care Services," Office of Health Planning, U.S. DHHS, Bethesda, MD, 1984.

Alpha Centerpiece: "Long-Term Care Alternatives: Continuing Care Retirement Communities," Alpha Center, Office of Health Planning, U.S. DHHS, Bethesda, MD, 1984.

Alpha Centerpiece: "Long-Term Care Alternatives: Innovations in Financing Chronic Care for the Elderly," Alpha Center, Office of Health Planning, U.S. DHHS, Bethesda, MD, 1984.

American Association of PSROs: Patients awaiting alternative care: "Issues and Recommendations," New York State Health Planning Commission, Albany, N.Y., 1981.

Andersen, W.F. "Achievements in Geriatric Medicine," Excerpta Medica, The Netherlands, 1979, as quoted by Koff, T.H. in Long-Term Care: An Approach to Serving Frail Elderly, Little, Brown & Co., Boston, Mass., 1982.

Anderson, O.W.: "Health Care: Can There Be Equity?" John Wiley & Sons, New York, N.Y., 1972.

Ansak, M.L. and R.T. Zawadski, "Triage: A Long-Term Care Study" in Zawadski, R.T. ed., Community-Based Systems of Long-Term Care, The Haworth Press, New York, N.Y., 1983.

Beland, F. "The Decision of Elderly Persons to Leave Their Homes," Gerontologist 24:2 (1984) 179-185.

Blumentahl, D., Schlesinger M. and P.B. Drumhelles, Harvard Medicine Project. Division of Health Policy, Research and Education, Harvard University, Cambridge, Mass., 1986.

Brecher C., Knickman J.R. and R.J. Vogel "Local Simulation of Alternative Policies for Financing Services for the Elderly" Medical Care 24:4 (April 1986) 363-376.

Brill, R.S. and A. Horowitz "The New York City Home Care Project: A Demonstration in Coordination of Health and Social Services," in Zawadski, R.T. ed., Community-Based Systems of Long-Term Care. The Haworth Press, New York, N.Y., 1983.

Brody, E.M. Long-Term Care of Older People, Human Science Press, New York, N.Y., 1977.

Brody, E.M. "Women in the Middle and Family help to Older People," Gerontologist 21:4 (1981) 471-480.

Brody S.J. and J.S. Magel "DRG: The Second Revolution in the Health Care for the Elderly," Journal of the American Geriatric Society 34:7 (1984) 16-20.

Brook, R.H. "Quality, Can We Measure It?" New England Journal of Medicine 296 (1977) 197.

Brotman, H.B. "The Aging of America: A Demographic Profile" in The Economics of Aging, National Journal Issues Book: Government Research Corporation, Washington, D.C., 1978.

Brown, E.R., "Medicare and Medicaid: The Process, Value and Limits of Health Care Reform" in Minkler, M. and C.L. Estes, eds., Readings in the Political Economy of Aging, Baywood Publishing Co., Farmingdale, N.Y., 1984.

Brown, T.E. and R.H. Learner "The South Carolina Long-Term Care Project" in Zawadski, T.R. ed., Community-Based Systems of Long-Term Care, Haworth Press, New York, N.Y., 1983.

Buchanan, R.H. and J.D. Minor, Legal Aspects of Health Care Reimbursement Section on Medicare. Aspen Publication, Rockville, MD, 1985.

Burke, G.C. and M.J. Koren "Home Care: An Industry on the Horizon." Business and Health, December 1984, 8-12.

Capistrant, G. "A Medicare Prospective Payment System for Skilled Nursing Facilities," Health Span 2:4, April 1985.

Childress J. "Paternalism and Health Care" in Robinson W. and M. Pritchard, eds., Medical Responsibility, Human Press, Clifton, N.J., 1982, as quoted in Generations Winter 1985, 32-33.

Clarke H. and B. Anderson, Culture and Aging, C. Thomas, Springfield, Ill., 1967.

Crichton, A., ed., Health Policy Making, Health Administration Press, Ann Arbor, Mich., 1981.

Crisis in Health Care: An Overview. Hearing before the Subcommittee on the Select Committee on Aging, House of Representatives, 98th Congress - First Session, U.S. Government Printing Office, Washington, D.C., 1983.

Davis, S.L. With Dignity: In Search for Medicare and Medicaid, Greenwood Press, West Port, CT, 1985.

Diamond L.D. and D. Bergman "The Social HMO: A Single Entry Pre-Paid Long-Term Care System," in Callahan J.I. and S.E. Wallack, eds., Reforming the Long-Term Care Health Care System, Lexington Books, Lexington, Mass., 1980, 185-213.

Dunlap, B.D. "Expanded Home-Based Care for the Impaired Elderly: Solution or Pipe Dream?" American Journal of Public Health 70:5 (1980) 514-518.

Eggert, G.M. and B.S. Brodows "Five Years of Access: What have we Learned?" in Zawadski, R.T., ed., Community-Based Systems of Long-Term Care, Haworth Press, New York, N.Y., 1983.

Etheridge, L., "An aging society and the federal deficit" in Milbank Memorial Fund Quarterly Health and Society, 62:4, Fall 1984.

Etzioni, A., "Old People and Public Policy," Social Policy, 6:1967 21-29.

Facts about Older Americans 1979, U.S. Bureau of Census, U.S. Government Printing Press, Washington, D.C., 1980.

Firman J. "Reforming Community Care for the Disabled Elderly" Health Affairs 2:2 (1983) 67-82.

Fisher C. "Differences by Age Groups in Health Care Spending" Health Care Financing Review 1 (Spring 1981) 65-70.

Freeland M.S. and C.E. Schendler "National Health Expenditure Growth in the 1980s: An Aging Population, New Technologies, and Increased Competition," Health Care Financing Review 4 (1983) 1-58.

Fullerton W.D., "Favorable Tax Treatment for the Elderly" in Conference Proceedings Long-Term Care Financing and Delivery Systems: Exploring some Alternatives, U.S. DHHS, HCFA, U.S. Government Printing Press, Washington, D.C., 1984.

Gadow S. "Medicine, Ethics and the Elderly," Gerontologist 20:6 (1980) 680-85.

Gibson R.M., D.R. Waldo and K.R. Levitt "National Health Expenditures" Health Care Financing Review 5 (1983) 1-32.

Glenn, John, U.S. Senator, in a Hearing of the U.S. Senate Sub-Committee on Aging. November 1985, as reported by the Gannet News Service.

Greenberg, J.N. and W.N. Lautz, "The Social/Health Maintenance Organization and its role in reforming long-term care" in Conference Proceedings: Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives, U.S. DPHSS, HCFA, U.S. Government Printing Press, 1984.

Hagen, R. "Medigap Insurance: Pitfalls and Progress," Business and Health 3:5 April 1986, 25-30.

Heinz, J., U.S. Senator and Chairman of the Senate Special Committee on Aging "The Search for Long-Term Care Solutions" Business and Health December 1984 5-7.

Hendricks J. and C.D. Hendricks, Aging in Mass Society, Winthrop, Mass., 1977.

Hickey T. and R.L. Douglas "Neglect and abuse of Older Family members," Gerontologist 21: (1980) 171-176.

Hirsch, b., Silverman H.A. and A. Dobson, Medicare Summary: Use and Reimbursement by Persons 1976-1978, HCFA, Baltimore, MD, 1982.

Hogan, A.J. and C.V. Getts "Bidding for Long-Term Care Patients," Institute for Health Planning, Madison, Wis., 1982.

Inglehart, J.K. "The Cost of Keeping the Elderly Well" National Journal 9 (1977) 1725-1727.

Jabobs, B. and W. Weissert, "Home Equity Financing of Long-Term Care for the Elderly" in Conference Proceedings Long-Term Care Financing and Delivery Systems: Exploring some Alternatives. U.S. DHHS, HCFA, U.S. Government Press, Washington, D.C., 1984.

Jazwiecki, T., "Financing Options for Long-Term Care Services," Business and Health 3:3 April 1986 18-24.

Jennings, M.C. and S.E. Krentz, "Private payment for long-term care: the untapped mechanism" Topics in Health Care 10:3 (Spring 1984) 1-21.

Kane R.L. and R.A. Kane, Values and Long-Term Care, D.C. Health & Co., Inc., Lexington, Mass., 1982.

Kane R.L. and R.A. Kane "Care of the Aged: Old problems in need of new solutions," Science 200: (1978) 913-919.

Kane R.L. and R.A. Kane "Alternatives to Institutional Care of the Elderly: Beyond the Dichotomy," Gerontologist 20:3 (1980) 249-59.

Kane R.L. and R.A. Kane "Long-Term Care: Can our Society Meet the Needs of its Elderly?" Annual Review Public Health 1: (1980) 227-53.

Kane R.L. and R.A. Kane, Long-Term Care in Six Countries, Dept. of HEW, National Institute of Health, Washington, D.C., 1976.

Kayser-Jones, J.S. Old, Alone and Neglected: Care of the Aged in Scotland and the United States, University of California Press, Barkely, CA., 1981.

Kobrin, F.E. "The Fall in Household Size and the Rise of the Primary Individual in the United States" Demography 131: (1976) 127-138.

Kodner, D.L., W. Mossey and R. Deluca Dapello "Nursing Home Without Walls": A Provider-Based Community Care Program for the Elderly" in Zawadski, R.T., ed., Community-Based Systems of Long-Term Care, Haworth Press, New York, N.Y., 1983.

Kodner, D.L., The Implementation of a Social/Health Maintenance Organization" in Conference Proceedings Long-Term Care Financing and Delivery Systems: Exploring some Alternatives, U.S. DHHS, HCFA, U.S. Government Printing Press, 1984.

Kovar M. "Health of the Elderly and Use of the Health Services" Public Health Reports 92:1 (1977) 9-19.

Koff, T.H. Long-Term Care: An Approach to Serving the Elderly, Little, Brown & Co., Boston, Mass., 1982.

Lamb S.J., C.H. Gassaway and E.K. Gallagher, eds., "Proceedings of A Symposium on financing Medical Care for the Aged," sponsored by the Caldwell B. Esselstyn Foundation, Claverack, N.Y., 1983.

Lee, G.R. "Kinship and Social Support of the Elderly" Aging and Society 5:1 (1985) 19-38.

Life Care Centers: An Alternative Delivery System for the Elderly, Information and Data Brief, U.S. Department of Health and Human Resources, U.S. Government, Washington, D.C. 1986.

Lifson A. and P. Leiberman "Financial Planning for the Future," Business and Health, December 1984, 14-17.

Lipman A. "Impact of Demographic Changes on the Family" Recent Advances in Gerontology: Excerpta Medica, The Netherlands, 1979, as quoted in Aging and Society 5:2 (1985) 19-38.

Little, V.C. "The Present and Future of Long-Term Care" Aging and Society 3:1 (1983) 123-130.

Long, S. and R.F. Settle: "Medicare and the Disadvantages Elderly: Objectives and Outcomes" in Milbank Memorial Fund Quarterly 62:4 Fall 1984.

Lopata, H. "Ethical Issues in Long-Term Care of the Aged" Journal of Geriatric Psychiatry, as quoted in Generations, Winter 1985, 30-34.

Lowy, L., Social Policies and Programs on Aging, Lexington Books, Lexington, Mass., 1980.

Marmor, T.R.: The Politics of Medicare, Aldine Press, Chicago, Ill., 1973.

McLachlan, G. The Planning of Health Services, Studies in Eight European Countries. WHO Regional Office for Europe, Copenhage, (Denmark), 1980.

Meeker, S.E. and N. Duff Campbel, "Providing for Dependent Care," Business and Health 3:7 (June 1986) 18-24.

Meiner, M. "The case for long-term care insurance" Health Affairs 2:2 (1983) 56-57.

Meiner, M. "The State of the Art of Long-Term Care Insurance" Conference Proceedings of Long-Term Care Financing and Delivery Systems: Exploring some Alternatives U.S. DHHS, HCFA, U.S. Government Printing Office, Washington, D.C., 1984.

Michael R.T., V.R. Fuchs and S.R. Scott "Changes in the Propensity to Live Alone: 1950-1976," Demography 17: (1970) 39-56.

Minkler M. and C.L. Estes, eds., Readings in the Political Economy of Aging, Baywood Publishing Co., Farmindale, N.Y., 1984.

Moon, M. "The role of the family in the economic well-being of the elderly," Gerontologist 23: (1983) 45-50.

Morris J.N. and S. Sherwood "Informal Support Resources for Vulnerable Elderly Persons: Can They be Counted on, Why do they Work?" International Journal on Aging and Human Development 18:(1984), 81-98.

Munnel A., "Paying for the Medicare Program" in Journal of Health Politics, Policy and Law, 10:3, Fall 1985.

National Center for Health Statistics, Health, United States: 1976-1977, U.S. Government Printing Office, Washington, D.C., 1977.

Neugarten, B.L. "Age Groups in American Society and the Rise of the Young-Old" Annals of the American Academy of Political and Social Sciences, September 1974, 187-8.

Neugarten, B.L., Age or Need? Sage Publications, Beverly Hills, CA., 1982.

Nissel M. "The Family Costs of Looking after Handicapped Elderly Relatives," Aging and Society 4:2 (1984) 185-203.

Nusberg, C., Innovative Aging Programs Abroad, Greenwood Press, Westport, Conn., 1984.

Pearson D. and T. Wetle "Long-Term Care" in Jonas S., ed., Health Care Delivery in the United States, 2nd. ed., Spring, New York, N.Y., 1981.

Pegals, C.C. Health Care and the Elderly, Aspen, Rockville, MD, 1980.

Pegals, C.C. "Institutional vs. Non-Institutional Care for the Elderly," Journal of Health Politics, Policy and Law, 5:205-212, 1980.

Pies, H.E., "Life Care Communities for the Aged--An Overview" in Conference Proceedings: Long-Term Care Financing and Delivery System: Exploring some Alternatives, U.S. DHHS, HCFA, U.S. Government Printing Press, Washington, D.C., 1984.

Quinn J.L. and J.H. Hodgson "Triage: A Long-Term Care Study" in Zawadski, R.T., ed., Community-Based Systems of Long-Term Care, Haworth Press, New York, N.Y., 1983.

Rosenblum, R., "Medicare Revisited: A Look Through the Past to the Future" in Journal of Health Politics, Policy and Law, 9:4, Winter 1985, 669-681.

Scholen, K., "An Overview of Home Equity Conversion" in Conference Proceedings Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives, U.S. DHHS, HCFA, U.S. Government Printing Press, Washington, D.C., 1984.

Schram, W., Aging and Mass Communication" as quoted by J. Shindul in Aging and Public Policy, 1985.

Shanas, E. "Family help patterns and social class in three countries" in Neugarten, B.L. ed., Middle Age and Aging: A reader in Social Psychology, University of Chicago Press, Chicago, Ill., 1968.

Shanas E. and G.L. Maddox "Aging, Health and the Organization of Health Resources" in Binstock, R.H. and E. Shanas, eds., Handbook of Aging Van Nostrand Reinhold, New York, N.Y., 1976.

Shanas, E. "Health Status of Older People: Cross-National Implications" American Journal of Public Health 64:3 (1974) 261-64.

Shanas, E. "Social myth as hypothesis: the case of the family relations of old people." Gerontologist 19:(1979) 3-9.

Shindul, J.A., in Aging and Public Policy, Williamson, J.B., Shindul J.A. and L. Evans, eds., C.C. Thomas Publishers, Springfield, Ill., 1985.

Skellie A., F. Favor, C. Tudor and R. Strauss, "The Georgia Alternative Health Services Project: Cost-Effectiveness Depends on Population Selection," in Zawadski, R.T., ed., Community-Based Systems of Long-Term Care, Haworth Press, New York, N.Y., 1983.

Somers, R.A. "Rethinking Health Policy for the Elderly: A Six-Point Program" Inquiry 17: (Spring 1980) 3-17.

Somers, A.R. "Long-Term Care for the Elderly and Disabled: A New Health Priority," New England Journal of Medicine 307:(1982) 221-6.

Somers, A.R. "The Geriatric Imperative" in the proceedings from A Symposium on Financing Medical Care for the Aged, sponsored by the Caldwell B. Esselstyn Foundation, New York, N.Y., May and October 1983.

Taeuber, C.M. America in Transition: An Aging Society, Bureau of the Census, Government Printing Office, Washington, D.C., 1983.

Teske, R., Office of Intergovernmental Affairs of HCFA in "Issues in Planning for Long-Term Care," DHHS-National Council on Health Planning and Development, Washington, D.C., 1983.

Treas, J., "Family Support Systems for the Aged: Some Social and Demographic Considerations," Gerontologist 17:(1977) 486-491.

The Swedish Health Services System. Lectures from the American College of Hospital Administrator's 22nd Fellows Seminar, Stockholm 1969; University of Chicago Press, Chicago, Ill., 1971.

Trends and Strategies in Long-Term Care, American Health Care Association, Washington, D.C., 1985.

U.S. General Accounting Office, "Assessment of the use of tax credits for families who provide health care to disabled elderly relatives," Report to the Chairman, Special Committee on Aging, U.S. Senate, Washington, D.C., 1982.

U.S. General Accounting Office, "The elderly should benefit from expanded home care but increasing these services will not insure cost reductions," Report to the Chairman of the Committee on Labor and Human Resources, U.S. Senate, Washington, D.C., 1982.

U.S. Department of Health and Human Services, Issues in Planning for Long-Term Care, Proceedings of conference in Washington, D.C., Health Planning Office, U.S. Government Printing Office, Washington, D.C., 1983.

U.S. Congress: Senate Special Subcommittee on Aging, Opportunities in Home Equity Conversion for the Elderly, 97th Congress, 2nd Session, 1982, Washington, D.C., 1982.

Vladeck, B. Unloving Care: The Nursing Home Tragedy, Basic Books, New York, N.Y., 1980.

Vladeck, B., "Reforming Medicare Provider Payment" in Journal of Health Politics, Policy and Law, 10:3, Fall 1985.

Vogel R.J. and H.C. Palmer, eds., Long-Term Care Prospectives from Research and Demonstrations. Health Care Financing Administration, U.S. Department of Health and Human Services, Washington, D.C., 1983.

Waldo, D.R. and H.C. Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States 1977-1984" in Health Care Financial Review, 6(1), 1984.

Ward, R.A. The Aging Experience, J.B. Lippincott, New York, N.Y., 1979.

Weiss, L.J. and B.W. Skalr "Project OPEN: A Hospital-Based Long-Term Care Demonstration Project for the Chronically Ill Elderly" in Zawadski, R.T., ed., Community-Based Systems of Long-Term Care, Haworth Press, New York, N.Y., 1983.

Weissert W. and B. Jacobs, "An overview of the national potential of home equity conversion into income for the elderly," a report prepared for the Home Equity Project, Madison, Wis., 1982, as printed in Alpha Centerpiece, May 1984.

Weissert W., Wan T. and B. Livieratos, "effects and costs of day care and homemaker services for the chronically ill," a report prepared for the U.S. DHHS, National Services Research, Hyattsville, M.D., 1980.

Wetle, T. "Long-Term Care: A Taxonomy of Issues," Generations X:2 (Winter 1985), 30-34.

Willging P., P. Kerschner and J. Perez, "Long-Term Care: The Malthusian Dilemma," Health Care Financial Management 4:12 (1984) 48-54.

William J.B., Munley A. and L. Evans, Aging and Society, Holt, Rinehart and Winston, New York, N.Y., 1980.

William J.B., Shindul J. and L. Evans, Aging and Public Policy, C.C. Thomas, Springfield, Ill., 1985.

Winklevoss H. and A. Powell, "Continuing Care Retirement Communities: An Empirical, Financial and Legal Analysis," Pension Research Council, Wharton School of Business, University of Pennsylvania, as reported in Alpha Centerpiece, 1984.

Zawadski, R.T., ed., Community-Based Systems of Long-Term Care, Haworth Press, New York, N.Y., 1983.