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NURSING HOME OWNERSHIP AND PUBLIC POLICY:
AN HISTORICAL ANALYSIS

A Dissertation Presented
by

R. R. Kaffenberger

Submitted to the Office of Graduate Studies, University of
Massachusetts Boston, in partial fulfillment of the
requirements for the degree of

DOCTOR OF PHILOSOPHY

June 1998

Gerontology Program

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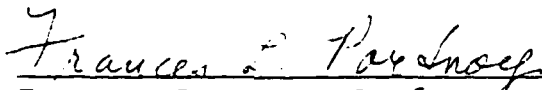
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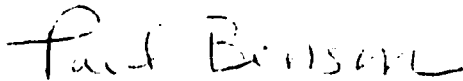
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ABSTRACT

NURSING HOME OWNERSHIP AND PUBLIC POLICY:

AN HISTORICAL ANALYSIS

JUNE 1998

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In the early days of the United States, care of the disabled elderly outside the home meant the public almshouse. By the 1920s, private, nonprofit homes for the aged were prevalent. More recently, private, for-profit facilities have grown to dominate the field.

For-profit ownership has been controversial. Underlying the controversy is the concern that quality might be lowered in order to enhance profit.

This study asks why most nursing homes are privately owned and why most privately owned nursing homes are operated for profit. It does so with reference to The Nonprofit Economy, in which Burton Weisbrod describes a 3-sector economy that includes public, nonprofit and for-profit organizations. Weisbrod's model contrasts the 3 sectors, in the way they gain access to capital, in the way they relate to their public or customers and in how they respond to varying levels of information about and demand

for their services.

This study uses secondary sources as well as primary sources such as state and federal government documents, newspaper reports, Congressional testimony, trade publications and interviews with experts in the field.

The study reaches three important conclusions:

1. Public facilities, like the almshouses, lost favor because of dissatisfaction with the quality of care they provided and high costs.
2. Government policies that enhanced income security and health care financing enabled private organizations to develop nursing homes.
3. During the period of rapid nursing home expansion, relatively few private, nonprofit organizations took advantage of the financial opportunities to open new nursing homes.

Despite many new facilities, quality of care remained a problem in nursing homes. The publication of Improving the Quality of Care in Nursing Homes in 1986 led to legislation and regulations that guarantee a higher level of quality in federally certified nursing homes.

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CHAPTER 1

INTRODUCTION TO THE STUDY

Nursing Homes Are Important Today

The residential health care facilities called nursing homes care for large numbers of people, usually elderly, who are too disabled to live alone or in a family setting. Some 16,000 such facilities in the United States consume about \$48 billion annually (assuming an average cost of \$82 per day) to care for 1,500,000 people. This is about 4.5 percent of the population over age 64 years (HDA, 1994). The largest portion of the funds spent for this care are public monies paid out by the Medicare and Medicaid programs. At the time of admission, about 18 percent of nursing home residents are covered by Medicare, some 26.9 percent are covered by Medicaid, 50.7 percent are paid for privately, and 4.5 percent use other sources of payment (Spillman & Kemper, 1995; Kemper & Murtaugh, 1991). Medicaid is the single largest source of funding for nursing home services in the United States, in part because conversions to Medicaid from private payment and from Medicare increase as the length of a nursing home stay increases (Leutz et al, 1992; Liu & Manton, 1989). Approximately 48 percent of nursing home revenues come from Medicaid and 68 percent of Medicaid expenditures for the elderly are spent on nursing home care (Hooyman and Kiyak,

1991). One knowledgeable estimate is that 25 to 40 percent of aged persons in the United States will be admitted to a nursing home at some time (Lewis et al, 1985; Liu, Manton & Liu, 1990).

The institutional long term care industry is one of the most important elements in the health care system of the United States. Persons living in nursing homes do so because of substantial disabilities which distinguish them from their contemporaries. Such residents need extensive and repetitive assistance from trained personnel to treat their disorders and to attend to their personal care.

Skilled nursing facilities are the backbone of the nursing home industry. Nursing facilities (previously called intermediate care facilities) and rest homes make up most of the remainder of the industry. These organizations care for millions of disabled older people, employ millions of professional, skilled and unskilled workers; and cost billions of dollars each year. The greater part of those dollars comes from one public source or another. Because the most common payor is Medicaid, the joint federal and state program that provides health services for the poor, billions of public dollars are used to support not only old, sick people, but a huge, private industry.

In the second half of the twentieth century nursing homes have become an essential component of the health care

spectrum. They are owned by governments and private entities. Roughly two-thirds are privately owned and pay taxes and are called "for-profit" facilities. The remaining third is predominantly (4:1) private, "not-for-profit" nursing homes and qualify for tax exemptions as charitable organizations. The remainder are publicly owned (HDA, 1994).

Care for the sick, poor, and elderly has gone on for more than three centuries in what is now the United States, but nursing homes in their current configuration are a relatively recent development. The rapid expansion in nursing home beds is even more recent. Nursing homes developed later than hospitals and, as their number increased, the proportion of facilities that were organized on the for-profit model increased. As Medicaid fueled this rapid expansion, various forms of real estate manipulation and outright fraud became common as investors sought to obtain huge profits in a short time. To this day there are serious public concerns about the extent to which the profit motive may diminish the quality of care in nursing homes.

Just as Medicaid has become the single greatest source of income for the nursing home industry, it and Medicare have become the source of the most forceful regulatory thrusts. State and federal standards for every element of nursing home operation have been established and are enforced as part of these Health Care Financing Administration (HCFA) directed programs (Medicaid and

Medicare). The nursing home industry has become arguably the most regulated subsector of the highly regulated health care industry. It may also be the most profitable direct services portion of the health care industry.

As this study will show, scholars have done some research related to ownership type in nursing homes (Arling, Nordquist and Capitman, 1987; Nyman, 1993), but little has been done to explore how nursing homes have come to be predominantly private and for-profit. Burton Weisbrod has examined the nature of ownership and the differences that may exist among public ownership; private, nonprofit ownership; and private, for-profit ownership in his book The Nonprofit Economy (Weisbrod, 1988).

Weisbrod's theories cover many different industries. He presents information related to health care, day care, education, research and development, recreation, libraries and information centers and entertainment. He finds some uniformity of themes among the most frequently occurring ownership types.

In this economist's assessment of ownership types (or institutional forms) Weisbrod identifies four themes. The four themes are; informational inequalities, diverse demands, sources of revenue and the nature of its outputs, and interdependence of institutional forms. Informational inequalities cause different sorts of institutional forms to deal differently with enhanced or reduced consumer

information. In health care, Weisbrod hypothesizes that for-profits would be more likely to take advantage of the customers' limited knowledge to increase profits while nonprofits and public entities might not.

Diverse demands is a phrase used to describe the whole range of demand variables and the way that different ownership types deal with them. For instance, for-profit organizations respond well to demand for items which can be produced in volume and sold individually. However, for-profit organizations have no real way of dealing with a communal need like national defense or flood relief requirements. The public sector does best with national defense because it is a very broadly shared need (or demand) with no specific economic market.

Revenues and outputs are largely self-explanatory. The facts that governments can tax, nonprofits benefit by tax free donations and membership dues, and for-profits gain revenue from sales, rents and service charges is related to the kinds of things (outputs) they do best. Finally, the interdependence of institutional forms highlights the need to have each of the ownership types doing the jobs it does best. These one sentence descriptions do not do justice to Weisbrod's theories but may help explain the use of his theories in this study.

Weisbrod's central interest is in nonprofits, but because interdependence is present, he discusses all three institutional forms or ownership types (Weisbrod, 1988).

In discussing the proprietary (for-profit) sector he observes, "The main strength of private enterprise is its efficiency in meeting demands at minimum cost" (Weisbrod, 1988, p.18). Nonprofits and governments, he finds, are less likely to be so efficient because their managers and officials may not, under law, share as fully in the fruits of such efficiency as managers and owners of proprietary organizations can. He cautions, however, that the private market responds to wants and needs only when they are expressed in financial form. Money and profit are at the center of proprietary activity. The implications Weisbrod draws from this are (1) that consumers who cannot pay for a good or service will not engage the interest of the private market and (2) in the proprietary marketplace consumers who cannot tell the difference between high quality and low quality will receive only low quality goods and services if they cost less to produce and can be sold at the same price as those of better quality.

As examples of reduced quality that might go undetected Weisbrod mentions reduced airliner maintenance by airlines and misuse of medications in a nursing home. He points to such unscrupulous cost cutting as one risk associated with the profit motive. A less direct risk is the possibility of

undesirable side effects for people other than customers. For instance, for profit educational trainers may issue certificates to students before they become entirely competent. A student's future employer and that employer's customers then may suffer from that students ineptitude.

Weisbrod supposes that proprietary organization is not suitable to meet the need for communal commodities. Services like defense, environmental safety and basic research will probably not be provided by the proprietary sector.

On the other hand, Weisbrod says that, "Collective action through government has the potential for correcting market failures" (Weisbrod, 1988, p.20). In discussing the public sector, Weisbrod emphasizes its relationship to its private cousins. "Since it has the power to tax, government can finance, subsidize, mandate or otherwise..."ensure services, he says (Weisbrod, 1988, p.20). It can provide a good or service, outlaw a good or service, regulate a good or service.

Government can tax, assuring it of a secure income stream that proprietary firms might envy. But there are usually legal prohibitions that keep government managers and workers from sharing in wealth derived from operating efficiency.

One benefit for government of not distributing surplus funds (profit), Weisbrod says, is that government workers

and managers then have little incentive to take advantage of poorly informed consumers. The disadvantage for government is that the absence of distribution of profit reduces any incentive to operate efficiently.

Weisbrod describes the nonprofit as a hybrid. It cannot collect taxes and it cannot share any surplus from efficient operation with its workers or board members. There rarely are share holders because there is little incentive to invest in shares that will never pay a dividend.

Conversely the nonprofit is free from the burden of some taxes, such as state and federal income taxes; and it does not usually have to respond to voters and political pressures as public entities often must. In Weisbrod's three sector model nonprofits, like governments, provide little incentive for workers or managers to be deceptive, therefore its consumers have greater faith that they are being dealt with fairly. For this reason Weisbrod argues that both the public and nonprofit sectors are better suited to provide nursing home care than the proprietary sector.

Other writers also deal with the question of ownership type in organizations. In Between Profit and State, Ware examines a variety of nonprofit entities in the United Kingdom and the United States. He studied banks, mortgage societies, professional organizations, trade unions and general charities to explore the nature of their operations

(Ware, 1989). Bennett and DiLorenzo take a different approach. In Unfair Competition they discuss the problems that for-profits face when competing for customers with nonprofits, which do not pay taxes and enjoy other special benefits. Their examples include health care, physical fitness and recreation (YMCAs compete with health clubs), educational computing and audiovisual products. Their thesis is that profitable and successful operations masquerading as charities (and, sometimes, as governments) undermine proprietary business operations by competing as any other business would (Bennett & DiLorenzo, 1989).

Ware and Bennett and DiLorenzo highlight the variety of industries that are affected by various kinds of ownership, although each study takes a different view of the efficacy of the different styles of ownership. The Weisbrod model of three kinds of ownership with well defined characteristics is the most useful in considering the ownership questions asked here.

Research Questions, Methods and Materials

This study seeks to provide answers to two of the most basic questions about nursing homes and nursing home ownership: Why are most nursing homes privately owned and why are most privately owned nursing homes operated by for-profit entities rather than nonprofits?

To provide answers to these two questions the evolution of care for the sick and elderly is reviewed. Historical

works, policy studies, and early state government documents are used to show how care modalities, such as the almshouse, hospital, and nursing home developed over time, and how the professions of medicine and nursing grew with them.

More recent events are viewed through scholarly works, journal articles and books, state commission reports, newspaper and magazine articles, federal government documents and, particularly, Congressional testimony. Because many aspects of developments in the nursing home field have not been well documented, personal interviews were used to supplement data from other sources.

Questions concerning the development of the nursing home industry and the nature of nursing home ownership have not been extensively examined in the literature. This study reflects the review of more than 200 articles and 150 volumes (including books, chapters in books, monographs, census data and government reports). Those materials that comment directly on the development of nursing homes in the United States or on ownership issues have been reviewed, and most often referred to in the study.

The 200 articles on long term care and health care included topics such as case management, nursing home quality, ownership characteristics, the intersection of profit and quality, the financing of health care (especially of long term care), cost and payment issues, case mix issues, staffing concerns, questions regarding home care,

hospital services, and other health care concerns. Many articles dealt with populations served, including the elderly and the disabled. A few articles took an historical perspective and some reported on related disciplines, including nursing and medicine. The publications in which the articles appeared were predominantly refereed social science and health care journals like Medical Care, The Gerontologist, Health Care Financing Review, The Milbank Quarterly, Public Health Reports, and the like. Some trade and business publications were also examined.

Books and monographs included such obvious titles as The Growth of Nursing Home Care, by Dunlop, The Pricing of Nursing Home Care, by Birnbaum, Lee and Bishop, and The Need for Long Term Care, by the Federal Council on Aging. There were also some less obvious choices such as Applied Health Services Research, by Thompson, and Sources of Revenue for the State Share of Public Assistance, by the Social Security Administration.

Finding Sources of Information

The computer age has made Congressional testimony and other government documents readily accessible for use. Although these materials have been available for a long time, computer searching and microfiche storage technology make them much more accessible today. They had previously been hidden from systematic examination by the sheer size of the collections.

Every listing of the Congressional Information Service on nursing homes and long term care was screened. These materials date from the 1930s to the present. The Congressional Information Service is a private organization in Bethesda, Maryland that indexes Congressional documents and provides them to libraries in the form of microfiche.

This electronic index is available for three periods. "Congressional Masterfile Number 1" covers the period from 1789 to 1969. It replaces a hardcopy index that filled 98 volumes. "Congressional Masterfile Number 2" covers 1970 to 1982 and is roughly as voluminous as the first masterfile. "Congressional Masterfile Number 3" indexes the period from 1983 to the present. As was done with other electronic search systems, a number of keywords were attempted; However, the search phrases "long term care" and "nursing home" captured the bulk of the available material. The masterfile series includes all publicly available Congressional testimony as well as Congressional documents such as committee reports, reports of the Congressional Budget Office, and other documents generated by Congress. Documents are catalogued by the originating house of Congress (House of Representatives or Senate), by Congressional session, by date, and by title. This study's reference list is formatted to reflect this organization of materials.

Clearly, not every relevant bit of testimony or reportage has been included here. Much of the total volume of material is repetitious. In fact, as this study will illustrate, the repetition sometimes involves the same person saying the same thing on several different occasions.

The study attempts to represent all important points of view on nursing home ownership that appear in Congressional documents, articles, books and monographs.

With regard to government documents, articles, books and monographs this study is largely inclusive. With the exception of popular media like newspapers and magazines, most materials specific to the topic were screened and are referred to in the study.

Books and articles were found in many ways. Some were known before the study was begun. Others were suggested by experts and advisors. The online search services provided through the University of Massachusetts Boston's Healey Library which include the Boston Library Consortium and OCLC's Firstsearch permitted reasonably thorough examination of likely sources. Firstsearch includes ten electronic indexes. Particularly useful were Medline, the computer version of the index of the National Library of Medicine, which contains articles on health and medicine, and Worldcat, an electronic catalog of books and materials in libraries throughout the world. Other electronic indexes provided little additional material on this topic.

In addition 20 interviews were conducted with experts in the field. These included lobbyists and policy analysts for trade associations, researchers, current nursing home administrators, regulators, executives and board members in Massachusetts, Maryland, New Hampshire, North Carolina, Wisconsin, Minnesota, Texas, and California. Three of the people interviewed are former presidents of state trade associations and two are former presidents of the American Association of Homes and Services for the Aged.

Respondents were selected on the basis of their expertise. The sample was extended by asking respondents to nominate other experts. The interviews were conducted by telephone in 1997. The resulting collection of expert opinions turned out to be remarkably consistent. The interview material is used to sharpen the insights gained from other evidence.

Examples of the questions that were asked are:

1. Why have for-profit nursing homes expanded more rapidly than not-for-profit facilities in recent years and in the past?
2. Why did for-profit nursing homes want to expand?
3. Why aren't there more publicly owned healthcare facilities in general and nursing homes in particular?
4. Why have nursing home chains emerged as such a powerful influence?

5. Do nursing home chains deserve the negative feelings some people attach to them?

Questions were asked differently of different people. For instance, Eulas Dortch was asked only one or two of these questions since he was interviewed primarily to increase understanding of the Hill-Burton program. Since Robert Morris had served on a special Massachusetts Commission on nursing homes in the early 1960s, much of the interview with him centered on that period and the commission's work.

Developing the Historical Context

This study includes an historical account of care for the old and sick and the development of nursing homes in the United States from the colonial period to the present. The history of long term care in the United States presented here goes beyond previous efforts. Such an extended descriptive effort was necessary to appropriately analyze issues of ownership in nursing homes.

This study will show that the reasons for the dominance of for-profit organization are consistent with Weisbrod's three sector model, yet different from the expectations he expressed in The Nonprofit Economy. On the basis of Weisbrod's analysis, it can be argued that nonprofits and government should be running nursing homes because the quality of nursing home care is difficult for the consumer to evaluate (Weisbrod defines the family as the consumer of

long term care, not the resident). Since the consumers have limited information, they should favor organizations like governments and nonprofits, which cannot increase their profits by limiting the resources used to provide care.

As this study traces the development of institutional long term care for the elderly, it finds that governments disqualified themselves as providers of long term care through very widespread incompetence, inadequacy, and scandal. Nonprofit organizations did not have enough capital available to expand their existing facilities or to build new ones at a rate sufficient to respond to market pressures for greater capacity. For-profit organizations sometimes compromised on quality, but they were able to build much more capacity. By satisfying the public demand for nursing home services the shareholders of nursing home companies made money. Such profits led to further investment, which led to additional capacity and profit which led, in turn, to more investment. Largely through this sort of growth, the for-profit nursing home has come to dominate the nursing home market in the United States.

How Many Nursing Homes Are There?

Appendix A provides some information about the rate of growth and the nature of ownership in the nursing home industry over the twentieth century. Unfortunately, there are severe limitations on available, aggregated data. However, the data presented, together with the remarks which

appear in the literature and in Congressional testimony, help give us some picture of how the industry came into existence and how it eventually grew.

One of the substantial tasks that still needs to be done to study nursing homes is to establish a good count by ownership, level of care, number of facilities and bed strength in the period from 1930 to 1970. State records and Department of Commerce records probably could be combined to present a reasonably full picture. The task could be daunting, for example, Department of Commerce data present each nursing home separately for certain years in the 1960s and 1970s, and there were more than 10,000 nursing homes in the country at that time.

Although the scarcity of information is troubling, available data do provide some insight into how nursing homes developed, particularly when it is combined with other information in the literature and in Congressional testimony. A sort of baseline is provided by the 1925 Bureau of Labor Statistics Bulletin 489. It covered 1,037 homes for the aged, of which 60 percent were operated by private, not-for-profit entities; 35 percent were operated by for-profit organizations and about 5 percent were operated by government bodies. Almshouses and county homes were not considered, nor were boarding houses that provided nursing care.

Between 1925 and 1930 many states enacted old age assistance laws, so that by 1931 the number of nursing homes would be expected to have grown significantly, and the Social Security Acts of 1935 would be expected to cause great increases by the early 1940s. Margaret van Wagenan's thesis tells us that there were more than 700 licensed care facilities in Massachusetts by 1943. But there is not another recorded aggregate figure to compare these numbers to until 1954. In that year there were either 6,539 or 9,000 nursing homes nationwide. The larger number was presented by the American Nursing Home Association (ANHA) and the smaller by the federal government. Given the limited quality of other federal nursing home information of that era, the ANHA estimate is probably more accurate. ANHA also estimated a total of 260,000 beds in those 9,000 homes.

The existence of ANHA and a number of state associations of for-profit providers is an indication that the for-profit sector had grown considerably and understood the need to influence government and society. What's more, there was a tone to the testimony in the various hearings that suggested the nursing home business was certainly an industry and a predominantly for-profit industry by 1954.

By 1957 ANHA figures showed almost 17,500 facilities with almost 400,000 beds. Eighty-nine percent were run by for-profit organizations, 3 percent were public facilities and 8 percent were nonprofit. The public sector facilities

averaged 100 beds apiece and the not-for-profits averaged 55 beds apiece. For-profit organizations must have included many former boarding houses which offered nursing services because they averaged only 17 beds per facility.

In 1961 the federal government listed 11,100 facilities with 421,800 beds, however, ANHA counted 600,000 beds in 23,000 facilities. The rapid growth in the number of facilities, the slow increase in the average number of beds per facility, and the marked dominance by for-profit entities continued.

In 1980, the Public Health Service (PHS) found 936 public facilities, 3,460 nonprofits, and 18,669 for-profit nursing homes. The public facilities averaged about 135 beds each, the nonprofits averaged about 98 beds, and the for-profits only 57 beds per facility. However, the roughly 1,072,000 beds under for-profit ownership still dwarfed the 465,000 under public and nonprofit ownership. This pattern has continued to the present.

Because the methodology used in counting facilities was not carefully discussed in each instance, it is not easy to determine why there was a difference in facility census among Health Data Associates (HDA), PHS, and the American Health Care Association (AHCA is the successor organization to ANHA). The ANHA, AHCA and HDA may have only counted intermediate care facilities, skilled nursing facilities and extended care facilities. The PHS, within its definition of

related care homes, probably included rest homes and board and care homes that received public reimbursement. Typically these facilities were great in number but small in bed strength. This would explain why there are differences about the total number of nursing home beds in the United States. The need for more accurate counts seems clear. They exist as a mass of very raw information but no one has bothered to aggregate them into a useful data set.

The Chapters

This study is primarily concerned with the development and expansion of nursing homes in the Medicaid era (1965-1995). However, an understanding of ownership issues in this recent era requires information about much earlier times.

Chapter Two traces the care of the old and disabled from the colonial era to the twentieth century. Massachusetts is used as the chief example, though many other states had similar policies and experiences (Rothman, 1971). Care of the chronically ill elder in the home was the most common arrangement, then and now. However, the older person who had neither family nor wealth was cared for by the community. By the beginning of the nineteenth century such public care usually meant an almshouse or poorhouse. Soon after these institutions were developed, complaints about them began to be heard and discussed in the legislature and elsewhere. Changes occurred in the care of

the institutionalized elder over time, but improvements were quite limited and the complaints continued. By the end of the 19th century, the public sector had been discredited as a source of care for disabled elders except under special conditions. Pressures were growing for public financial support of long term care, rather than public institutionalization of the sick and old. This set the stage for the development and expansion of private ownership in the delivery of care services for the chronically disabled elder. Chapter Three reviews economic and social programs which had important effects on the elderly and on health care from the late nineteenth century to the 1930s. Social Security has certainly been the most important program in the development of nursing homes in the twentieth century. But its origins are related to the Charitable Organization Societies, workman's compensation insurance, and old age assistance programs which preceded it. Without the late nineteenth and early twentieth century interest in social insurance and income support for the poor elder, Social Security might have emerged in some very different form.

Chapter Four looks at Social Security from development and inception to the 1950s, and considers other, parallel, social and health programs. Old age assistance in Massachusetts, and in other states, had provided disabled elders with sufficient funds to purchase residential and

nursing services from board and care homes. These facilities and the homes for the aged were the forerunners of the modern nursing home. The coming of Social Security guaranteed prosperity for these institutions by providing yet more generous financial arrangements for the elderly population and by specifically excluding residents of public institutions (such as county homes and almshouses) from the program.

Changes have since occurred in the Social Security program, many of which enhanced financial opportunities for nursing homes. Other government programs, like Hill-Burton and FHA loan guarantees also made financial resources available to nursing homes. By the late 1950s, the nursing home industry was healthy and profitable. For-profit ownership had achieved a position of dominance over nonprofit ownership, both in the number of facilities and the number of beds. The presence of large sums of money in the nursing home marketplace was largely the result of government programs. The for-profit, or proprietary, sector had responded to the opportunity for profit, just as Weisbrod's model suggested it might. However, concerns about quality were rife and real.

Chapter Five is concerned with Kerr-Mills (Medical Assistance to the Aged), Medicare and Medicaid from the late 1950s through the early 1970s. It took years of hearings and political effort to get the Kerr-Mills Act passed. The

discussions and arguments leading to its passage reflected earlier societal experiences as a shared memory or cultural predisposition. For instance, there was no prominent discussion of providing care for the elderly in public facilities, very probably because that idea had long since been cast aside. Those earlier experiences framed the Medicare and Medicaid legislation.

Chapter Six describes the development of Medicare and Medicaid as they affected nursing homes during the 1970s and early 1980s. These programs brought more money into nursing home services than had ever been available before. The resulting capacity expansion was unprecedented in scale, but quality remained a problem. In 1986, the publishing of Improving the Quality of Care in Nursing Homes and the reform package that was passed into legislation in 1987 ('87 OBRA) went a long way toward resolving many of the long standing quality concerns (Institute of Medicine, 1986).

Chapter Seven reviews and analyzes the other chapters and concludes that the dominance of private and for-profit providers can easily be understood by examination and analysis of the events which have occurred. Understanding of these results is enhanced by the Weisbrod three sector model, though the results vary from his expectations. Concerns consumers had about efficiency short changing quality have been controlled by extensive regulation.

Appendix A presents some limited, tabular data on the development of nursing homes in the United States in the twentieth century. Appendix B briefly presents an exception to the general pattern of ownership which occurred in the upper Middle West.

CHAPTER 1

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CHAPTER 2
CARE OF THE OLD AND DISABLED FROM THE COLONIAL ERA
TO THE TWENTIETH CENTURY

This chapter reviews the services received by the old and sick from the colonial era to the beginning of the twentieth century. In the late colonial and early federal periods most older people were cared for by their families at home. However, poor elders separated from their families were relegated to community care or almshouses, some of which persisted into the twentieth century. These facilities had neither nurses nor doctors. Although both medicine and nursing, as we know it, developed during this period, it was very late in the nineteenth century before the hospital began to emerge as a site of curative care for the very sick. By that time, the almshouse had fallen into disrepute among the public and the practice of caring for sick people in the nurse's own home foretold the beginning of nursing homes. Municipal, county and state governments compiled a dreadful record as caretakers of the old, sick, poor elderly. Principally through almshouses, poorhouses and county homes, government efforts were inadequate or abusive and cost vast sums of money.

This chapter describes selected events and activities to show how the public sector eventually disqualified itself

as the most likely operating organization to care for the chronically sick or disabled and old. These services were usually provided by state, county and local governments. Of course there were differences amongst the states. However, the few scholarly efforts that address these matters suggest that generalization across states is reasonable.

Massachusetts is used as an example here.

The Colonial and Federal Eras

Nursing homes have existed since the beginning of this century. But the disabled and infirm have needed help from the earliest days of New England, long before the emergence of the United States. Then as now, most of these disabled people have been old. Of course, "old" is a variable term. Health was such a severe problem at the end of the colonial era that the average age in the United States was 16 (Fischer, 1977). In 1726 Cotton Mather said that only three percent of the population lived to age 65 (Fischer, 1977).

By the first decennial census (1790), Massachusetts males under age 16 no longer made up more than half the male population, indicating that a trend toward aging of the population had begun. The 1820 census found that about 15 percent of men and 17 percent of women were over age 45. In each of four decennial census (1790, 1800, 1810 and 1820), the number of women exceeded the number of men and the percentage of women in the oldest age group increased

slightly with each census. The most telling feature of these data was the rapid increase in population from one decade to the next. The Massachusetts population rose from 190,582 in 1790 to 264,265 in 1820 including both the natural increase of the existing population and migration (United States Decennial Census, 1790-1820).

Then, as now, the most common form of long term care was home care. John Demos, a social historian of the United States colonial era, tells of the elderly exchanging their wealth for care. He quotes a grateful mother who rewarded her daughter in her will for years of personal care the daughter had provided during the mother's infirmity. Other wills required that the beneficiaries care for the benefactor in return for a portion of an estate (Demos, 1978). One such will said "I bequeath to my cousin Daniel Gott all my neat cattle and sheep and horse-carts, chains, plow, and tools . . . in consideration that he is to remove his family and come to live with me and my wife at Lynn during our lives and carry on our husbandry affairs" (Demos, 1978, p.s270).

Family care is still the most frequent form of long term care (Leutz et al, 1992; Henry, J.P.,1988). In social service and health care circles the fact that long term care is provided primarily by families is a given. In the colonial era each town or village looked after its

own needy residents. One view of the colonial era is that it was a religious and pragmatic time. The afflictions of insanity, poverty, weakness, and abandonment were seen as a reflection of the will of God. It was thought there was little purpose to altering the causes of such conditions, but every reason to manage them humanely and efficiently (Lidz et al. 1992; Moroney & Kurtz, 1975). Responsibilities were local. Each town or village looked after its own, and help was tailored to the need of the individual and to the resources available. When family members were available and upstanding, they took care of such afflicted persons. But when the local jurisdiction needed to intercede, the measures it took were likely to be incremental and focused on the individual case. At first, someone might simply need to be given some food. If lodging was required, needy residents were sometimes boarded with other families, in fact they might be boarded with one family for a while and then moved on to another (Friedlander, 1955). If necessary, a small house or cabin might be provided. Solutions were not systematic but were adjusted to the particular people and the problems that emerged (Lidz et al, 1992: Moroney & Kurtz, 1975).

In Massachusetts, the question of who was responsible for whom was codified at an early time. Paupers were those who lacked the means to care for themselves, and the statutes that defined responsibility for such persons or

families were called "pauper laws." As early as 1636, state legislation gave to county courts ("shire courts" in the language of the time) and their officials the authority to determine which town might be responsible for a given person or family. A statute was established in 1675 which made the Commonwealth itself responsible for the support of persons who may have been driven from their homes by such events as the Indian uprising called "King Phillip's War". The Commonwealth would dispatch this responsibility by reimbursing those towns that provided such relief (Board of State Charities, 1864). This support came to be known as "outdoor relief," in contrast to "indoor relief," which was the provision of services by the Commonwealth in its almshouses, state hospitals and other facilities. Outdoor relief provided funds to support paupers in private homes or in the very small public facilities of some towns (State Board of Lunacy and Charity, 1893; Friedlander, 1955).

Increased populations in the towns and villages led to greater numbers of needy. In the later colonial era, bigger communities sometimes provided larger dwellings which could house a number of individuals or families who depended on public or charitable resources (Lidz et al, 1992; Board of State Charities, 1875).

Josiah Quincy's report of 1821 sheds more light on the process of supporting the poor. He feared that outdoor relief was inefficient, so he recommended the development of

almshouses or workhouses to limit cost and encourage good habits. He also suggested that agricultural pursuits were the most suitable to improve the health of the pauper and the profit of the state (Board of State Charities, 1864). His concern may have been piqued by a rise in the annual cost of supporting paupers from about \$14,000 in 1783 to about \$47,000 in 1820 (Board of State Charities, 1864). The Quincy report is valuable because it states the thinking behind the development and use of almshouses in Massachusetts. It also contains letters which describe the situation in many cities and towns of the Commonwealth. Quincy wrote:

The principle of pauper laws is that of a state, or public, or, sometimes called, a compulsory provision for the poor. The poor are of two classes. 1. The impotent poor; in which denomination are included all, who are wholly incapable of work through old age, infancy, sickness or corporeal debility. 2. The able poor; in which denomination are included all, who are capable of work, of some nature, or other; but differing in the degree of their capacity, and in the kind of work, of which they are capable.

With respect to the first class; that of poor, absolutely impotent, were there none other than this class, there would be little difficulty, either as to the principle, or as to the mode of extending relief.

But another class exists; that of the able poor; in relation to which, and from the difficulty of discriminating between this class and the former, and of apportioning the degree of public provision to the degree of actual impotency, arise all the objections to the principle of the existing pauper system. The evils, also, which are attributed to this system, of diminishing the industry, destroying the economical habits and eradicating the providence of the labouring class of society may all be

referred to the same source; - the difficulty of discriminating between the able poor and the impotent poor and of apportioning the degree of public provision to the degree of actual impotency.

This difficulty, cannot, apparently, be removed by any legislative provision. There must be, in the nature of things, numerous and minute shades of difference between, the pauper, who, through impotency, can do absolutely nothing and the pauper, who is able to do something, but that, very little. Nor does the difficulty of discrimination, proportionally, diminish as the ability, in any particular pauper, to do something, increases. There always must exist, so many circumstance of age, sex, previous habits, muscular, or mental, strength, to be taken into the account, that society is absolutely incapable to fix any standard, or to prescribe any rule, by which the claim of right to the benefit of the public provision shall absolutely be determined. The consequence is that the admission, or rejection, of the claim to such relief is necessarily left to the discretion of Overseers; or to those, who are intrusted by law, with the distribution of the public charity (Quincy, 1821, p.4-5).

In this part of the report, Quincy, on behalf of the committee with which he was working, defined paupers as old, sick people as well as infants, the younger disabled and the able bodied poor. He highlighted the difficulty of dealing with these disparate groups within a single mode of relief; defined the operation of such relief as a task for "Overseers" who, he went on to say, were given to unwonted generosity. One implication of these comments was that if the old, poor and disabled (the impotent) were the only ones involved, the problem would have been simple. It was the need to avoid excessive expenditures for those who may have

been less worthy that necessitated a more disciplined approach. In his report Quincy then went on to discuss the problems caused by excessive generosity.

The necessity of entrusting this discretion, the class of society to which it must be entrusted, and the circumstances and feelings, under which such distribution must be made, are the proximate causes of the evils, resulting from a public, or compulsory, provision for the poor.

If the means placed under their control are confined to provision for the poor, in public poor, or alms houses, the effect of these dispositions and feelings appears, in the ease, with which admission was obtained; the kindness with which the poor are treated, during their residence, and in the superiority of the food of the public table, to that to which they have been accustomed. If those means consist in funds, the same temper and feeling predominate, in their distribution. It is laborious to ascertain the exact merit of each applicant. Supply is sometimes excessive; at other times misplaced. The poor begin to consider it as a right; next, they calculate upon it as an income. The stimulus to industry and economy is annihilated, or weakened; temptations to extravagance and dissipation are increased, in proportion as public supply is likely, or certain, or desirable. The just pride of independence, so honorable to man, in every condition, is thus corrupted by the certainty of public provision; and is either weakened, or destroyed according to the facility of its attainment, or its amount (Quincy, 1821, p.5-6)."

In these paragraphs from his report we hear the tone of severity which may be related to the sorts of religious and social ideas mentioned earlier in this chapter. They also speak of a singular concern for expense in the care of these wards of the state.

In his report Quincy described four different ways of providing relief for the poor. The first mode was by

letting a poor person out to board with the lowest bidder. He dismissed this as a solution only for small towns, because of its likely expense. The second was by letting all the poor out to board with one lowest bidder, this was much like a poor house and would be less expensive than the first. The third was to provide supplies or money for persons in their own houses, which, he stated, would lead to abuse and mismanagement. The fourth mode was the poor or alms house. Quincy highlighted experience in England that proved this to be the best mode, "as respects the better condition of the poor, and also the reduction of expense." (Quincy, 1821, p.8).

Beyond the pragmatic there was a moral temperament concern that emerged from the report. Quincy concluded that one of the other great advantages of the "alms house" was that it might have been the most effective of these modes when it came to reducing various evils within the serviced population, intemperance being the most common and problematic (Quincy, 1821).

The Quincy Report appendices include financial information that detailed the increased expense of poor relief and reports from 29 cities and towns. These town reports focus mainly on the expense of caring for the poor. Only Danvers calls its facility a "Charity House" rather than a poor house or almshouse (Quincy, 1821, p.18).

Andover complained about the medical bills it faced if it allowed people to receive cash of 60 cents per week at home rather than living in the poor house. However, the other town reports make it clear that Andover's almshouse costs were about half that of many towns (Quincy, 1821). We know that Andover's almshouse was a poorly maintained, nine room farmhouse (Rothman, 1971). Very little was said about the old and disabled. Most of the local reports focused, as Quincy had, on the expense of services and the negative qualities of those being served in almshouses.

The first almshouses appeared in places like Boston, New York, and Philadelphia as they developed into bustling cities and trade centers. Similar to the charitable homes of other places, the almshouses were just bigger. They not only took in local unfortunates, but might also care for sick travelers or those no longer fit for society. They did not represent an ideological departure from the village response of paying a neighbor to take in a needy towns person. They were simply bigger and more efficient (Lidz et al, 1992). An increasing number of towns and villages had also centralized their pauper services. Even before 1800, 46 towns in Massachusetts had built or purchased structures to house paupers (Board of State Charities, 1876, p.cxxvii).

Josiah Quincy's report on behalf of the Committee on Pauper laws has a somewhat harsh and singularly pecuniary

tone. That tone continued throughout the nineteenth Century in other such reports (Rothman, 1971).

The 1864 "First Annual Report, Board of State Charities" makes a distinction between the Massachusetts state almshouses and the poorhouses of the towns and cities. State almshouses were opened at Monson, Bridgewater and Tewksbury on 1 May 1854. The Hospital at Rainsford Island, in Boston, was not included because it was a hospital for the sick. Yet the modern reader is led to suppose that the differences between the hospital for the sick and the almshouses may not have been so great as they could have been. This document expressed great concern for the continued expense of almshouses, it noted that there continued being a substantial increase in cost from 1820 to 1830 despite the separation of the current State of Maine from the Commonwealth during that time. An 1832 commission of the Massachusetts legislature suggested that the Commonwealth separate itself from the costs of poor relief entirely, but that plan was not accepted.

In summarizing the work of the state almshouses this report states, "...these institutions have a double function: they serve as residences and as receptacles." As in other documents, the old, sick and disabled are not specifically listed as a class served by these facilities (Board of State Charities, 1864, p.252). However, a census

taken the following year shows the average age of applicants for relief (most of whom were served in almshouses or poorhouses) as 49.1 years, an advanced age for that time (Board of State Charities, 1866). Since we know that children, unmarried women, young inebriates, aliens and the insane were counted as part of the inmate population, it is clear that there must have been a good number of old people there to reach such an advanced average age. They were people who, in many cases, would be served in nursing homes today. The Massachusetts State Board of Charities reports of 1865 and 1866 were similar. The board was concerned with expense, with the unworthiness of the inhabitants of the state almshouses and with strategies to limit the number and expense of inmates to the state. The "Second Annual Report, 1865" contained a section which focused on the special classes of the deaf mutes and the blind (Board of State Charities, (1865-1866) This introduces the topic of separate facilities for special classes of inmate based on their disabilities.

The Move to Separate Facilities

Eventually the logic of focusing on the causes and possible cures for dependency emerged, and facilities began to be organized around the nature of individual problems. Up to this point, facilities for those in need were simply an outgrowth of community based services. Around 1790 the

idea of having separate facilities began to take root and led to a variety of early institutions. There were orphanages, asylums, workhouses, penitentiaries, and almshouses. Individuals were separated from society according to their dependent status. Further, they were separated into facilities that isolated or corrected the condition that led to that status. For some, this may describe the distinct quality of institutions (Lidz et al, 1992; Rothman, 1971). In Massachusetts, this turn to specialized facilities as a solution may have been an idea in 1790 but the first specialized institution was the Boston Dispensary (now Massachusetts General Hospital), established in 1801. The Insane Asylum at Somerville opened in 1818. The Insane Asylum subsequently was moved to Belmont and became McLean Hospital; other facilities were organized to care for deaf mutes, the blind, idiots, and those with vision problems (State Board of Charities, 1876).

One group of special concern was the insane. One list of those for whom the almshouse was appropriate included, "Such insane persons of the same class as have been removed from Lunatic Hospitals as incurable but harmless", (Board of State Charities, 1864,p.252). In 1865 they made up only about 1 percent of the population served (Board of State Charities, 1866), but continued to be intermingled with the old and sick. The recognition of insanity, as well as the number of cases may have grown as a proportion of the

population during the 19th century. In 1850 there were about 15 thousand cases of insanity in a United States population of about 21 million. By 1880 there were about 90 thousand cases in a population of 50 million. The movement toward institutional development had included state asylums. Often family members would seek the admission of their relatives. Particularly in the later part of the nineteenth century, the old and demented might be committed to these burgeoning state hospitals. A good deal of additional asylum or state hospital capacity was built after 1870. In many cases these facilities were built adjacent to almshouses (Grob, 1983). Massachusetts was one of the first few states to build state hospitals for the insane. Worcester State Hospital opened in 1833, Taunton State Hospital opened in 1854 and Northampton in 1858. The Asylum for the Chronic Insane at Tewksbury was on the almshouse grounds and was run by the administration of the almshouse when it opened in 1866 (Board of State Charities, 1875).

Lidz and his colleagues suggest that the early, puritanical rejection of the unfortunate, mixed with the impersonality of the almshouse or workhouse, created deteriorating conditions. Even in small villages, where those in need were cared for individually and well, there was a sense that their misfortune was a result of their being unworthy in the eyes of God. The idea that poor moral habits contributed to ill health and destitution became more

prominent as time passed and institutions grew in size. "The colonial emphasis on compassion and acceptance of responsibility for other community members disappeared," Lidz notes (Lidz et al, 1992, p. 26). It was replaced by the idea that those who had to rely on themselves should become responsible and productive rather than accept charity:

In the Colonial period, the immigrants to Massachusetts were a substantial and self-supporting class. But the increase of trade and the stimulus of easy living soon brought to our shores a host of poor and worthless persons, against whose intrusion into the community the old Puritan discipline no longer had force. Consequently, we find the provincial laws everywhere becoming more stringent against vagrants and strangers, and the conditions of pauper settlement were made more difficult at each revision of the statutes. (Board of State Charities, 1876, p.cxi).

In the early nineteenth century, institutions were further organized to take on a quality of routine, discipline and rigor. Schedules for work and dining emerged, and large groups became associated in a lockstep life. Even uniform articles of clothing, identifying the wearer as an institutional person, became common. The state almshouse at Monson was turned over, for the most part, to the care of children, who were sent there from the other almshouses. While the young had orphanages, the insane had asylums, and lawbreakers had penitentiaries, the poor, disabled, old and sick were mixed together with other poverty stricken unfortunates in almshouses or workhouses or

both. Little work and few alms were available in these facilities (Lidz et al, 1992; Board of State Charities, 1865) Thus, impersonal, custodial care emerged as the norm for a great many people, the old and indigent among them.

Along with Vladeck in Unloving Care, the Moroney and Kurtz chapter in Long Term Care, and Rothman's The Discovery of the Asylum, Lidz and his colleagues present one of the few (if brief) descriptive histories of almshouses and nursing homes by scholars. The information they present, as with Vladeck, and Moroney and Kurtz, is perfectly consistent with the information available in Massachusetts records. Rothman adds credibility to the implication that Massachusetts experience may represent broader trends. In his chapter, "The Almshouse Experience" he points out the similarity of Massachusetts policies and facilities to those of New York, Pennsylvania and other states. In his chapter on the colonial era he notes that other colonies often followed Massachusetts' example (Rothman, 1971). These scholars suggest that the Massachusetts experience was similar to that of other states.

Medicine Emerges

Noticeably lacking from the descriptions of care for the infirm and disabled is any substantial mention of nursing or medicine. Medicine did not then exist as we know it today. As Paul Starr noted, "Care for the sick was part of the domestic economy for which the wife assumed

responsibility" (Starr, 1982, p.32). This comment may reflect on the role of nursing as well as medicine and help explain why they were different in the early colonial era from what they are today. The development of these professions is of interest because they are so important to the modern nursing home and because nursing homes have developed as they have in conjunction with nursing and medicine.

The view that, "Health came from God . . . not from doctors," was important (Thomas, 1971, p.32). In the predominantly puritan society of the eighteenth century, affliction and disease were viewed as the expression of God's will. Although there may not have been any objection to attempts to help sick people, there was a sense that attempted cures could be successful only as God willed. Therefore, the absence of extensive medical care at that time is not surprising.

In addition, medicine did not appear to be particularly effective. In Starr's The Social Transformation Of American Medicine (1982), there are numerous examples of the primitive quality of medical knowledge in the colonial era and later. For example, Benjamin Rush, one of the most prominent physicians in the eighteenth century, insisted to his students at the Medical College of Philadelphia that bloodletting was the only curative technique of assured

value and to proceed with it, no matter how weak the patient.

By the Jacksonian era (c. 1820) a number of medical schools had emerged and physician licensing had begun in some states. Yet the very timbre of the era undermined a potentially elitist profession like medicine. Starr describes it as a time when the country became,

more egalitarian and less equal. Democratic ideas, manners, and institutions became more widely and firmly established, while in the towns and cities, the distribution of wealth and power grew more highly concentrated. Just as the economic polarization of the times created ever more impersonal institutions, the spreading of egalitarian rhetoric and thought blocked the protection and professionalization of medicine which might have injected its use more forcefully into facilities caring for the sick and disabled. (Starr, 1982).

During this era, patterns of training and licensure common in the twentieth century were despised by the public as protection of unwarranted privilege and elitism. What sorts of health care might be useful and productive was a topic of public controversy and disagreement (Riska, 1985).

So, as public opinion remained mixed regarding acceptance and support of medicine, the growing institution of the almshouse or poor house continued to provide little real health care for the sick or disabled.

The Nursing Profession Develops

Starr makes little mention of nursing. If medicine and pharmacy are the curing disciplines, nursing is the caring

discipline. But nursing had little professional currency in the eighteenth and early nineteenth centuries. Dock and Stewart's history of nursing explains:

Nursing and medical work were not encouraged by the early Puritan spirit, which regarded disease as punishment for sin, revived the superstitious notions of witchcraft, and labored under a heavy belief in infant damnation and other hopeless doctrines. (Dock & Stewart, 1938, p. 139).

In their Short History of Nursing (1938) Dock and Stewart discuss hospital orders in Quebec and the development of nursing and hospitals by the Dutch at Manhattan. But they make it clear that, in puritan New England nursing was not valued because of religious perceptions about disease and disability, and that it was, as Starr suggested, strictly a domestic responsibility.

As some hospital facilities were developed in the nineteenth century, professional nursing was carried out mostly by women in religious orders founded in Europe and was limited to hospitals (Dock and Stewart, 1938; Kalisch and Kalisch, 1986). Yet the domestic responsibility of women for health care in family settings intensified; it became increasingly desirable for housewives to be knowledgeable about the care of the sick. This situation gave rise to such organizations as the Ladies Physiological Institute of Boston, which held lectures and discussions of human health (Verbrugge, 1979).

With the exception of the few hospital facilities which were developed, nursing remained in the hands of housewives until the Civil War. Friends and neighbors were included in the circle to be cared for. Cookbooks commonly had passages related to the care and feeding of the infirm and disabled. Doctors might sometimes be called in if the home remedies had not worked, and if there was still time for further consideration of the problem. More often, the domestic nursing of an untrained wife, mother, daughter or woman neighbor either brought back health or comforted death (Dolan, 1978).

Thus, around 1850, most old, frail, infirm or disabled people who could not care for themselves were helped by their families. In some cases a religious order or other helpful group might offer care.

However, if anyone were estranged from or had lost their families and friends they were doomed to the almshouse or poorhouse. These facilities offered no medicine as we know it, no nursing as we know it, and all the burden of a stigma that may still persist in society for the outcast and unfortunate (Lidz et al, 1992; Moroney & Kurtz, 1975; Dunlop, 1979). We know that in Massachusetts alone, tens of thousands of old people occupied almshouses each year of the mid-nineteenth century (United States Census, 1860).

Changes in Care of the Aged

The watershed years before, during and after the United States Civil War were a time of change for those in old age, for medicine and for nursing. Perceptions of the aged moved from romanticism to realism. Puritan society had found advancing years an indication of election while the emerging era after 1865 saw old age as a period of decline. Customary roles and social importance were removed from the aged, changes consistent with "the pessimistic version of Social Darwinism" then in vogue. (Achenbaum, 1978, p.40)

Realists began to view survival to an old age not in the terms of either the puritan and romantic but in the terms of the rational. The application of science to matters of public health and the promotion of sanitation and hygiene produced benefits that could be observed. Some of the ideas of doctors, biologists, and engineers became more important and the future lay in their ideas and discoveries rather, than in the concepts of righteousness or wisdom of the aged (Achenbaum, 1978).

The late nineteenth century saw the almshouse and the poorhouse decline further as they became more custodial, more distant from every day society and focused increasingly on the care of the indigent immigrant (Rothman, 1971). The number of immigrant poor was growing. By the early twentieth century, as immigration continued to swell the ranks of the poor, the progressive movement brought concern

for the conditions in almshouses and poorhouses into the public political discussion. In addition the abandonment of the chronically ill elderly became a major public concern in the early twentieth century (Lidz et al, 1992; Dunlop, 1979).

In Massachusetts in 1894 only 77 town and city almshouses were listed as "good" by the official visitor of the state Board of Lunacy and Charity, while 46 were only "fair" and 19 "poor". Thus almost half were of questionable quality by the standards of the era (State Board of Lunacy and Charity, 1894). There was public concern regarding the number of children in almshouses, the view that almshouses were sites for the spread of disease, and the possibility that foreign countries were dumping their paupers on Massachusetts purposefully (Board of Charities 1865, Board of State Charities 1875, Board of Charity and Lunacy 1894). As the nineteenth century came to an end, these almshouses and poorhouses may have been worse places for the old and sick than they had been at the beginning of the century. For the poor they were still the only real alternative to family care. The rare exception would be those who belonged to a religious or fraternal group that maintained one of the few charitable homes for the aged.

Medicine Becomes a Profession

For medicine the latter half of the nineteenth century continued the intense competition for influence and status

amongst physicians, herbalists, alternative care methodologies like chiropractic, and out and out frauds, typified by snake oil salesmen. Several factors combined to alter and elevate the profession. Between midcentury and the 1930s medicine changed from one of many competing and sometimes questionable modes of care to the dominant health care discipline (Starr, 1982; Rogers, 1986).

Two factors which are often overlooked in the development of modern medicine are transportation and communication. In rural towns and villages doctors could see only a few patients a day by traveling from one patient's house to another. As industrial and commercial revolutions brought more and more people from the farms to larger towns and cities, there were more patients within easy distance of physician's offices.

It was a time when the doctor was summoned when people were quite sick. Someone had to travel to the physician's office or residence to get his help. When summoned he traveled to the patient's house, hoping the patient had not deteriorated too badly or died in the meanwhile. In small towns, the coming of hard surfaced roads and telephones in the second half of the century was a great help. In a time of virulent and widespread contagious disease the telephone enabled families to let the doctor know about sick people in crisis without leaving the sick person unattended. The

replacement of the one horse shay by the automobile was another such step (Starr, 1982).

Though these changes may seem secondary, they were very important in bringing medicine into the minds of people and separating it from the myths and superstitions that characterized much of its competition. By 1900 regular physicians (allopaths) dominated the medical field with some 110,000 practitioners; the next largest group was the 10,000 homeopathic practitioners (Riska, 1985).

During this era hospitals also began to emerge as places of allopathic curing. They had been a place for poor people with contagious disease to die or a residence for the chronically diseased. But with the advent of such new ideas as sanitation and hygienic procedures, their images and use began to change. The increased use of hospitals by the sick meant that greater numbers of a physician's sickest patients were in a single location, permitting a more efficient practice of medicine. Another effect of the broader use of hospitals was improvement in practice, because of collegial information sharing, frequent observation of patients, a clean environment, and other professional assistance, particularly trained nursing services (Starr, 1982; Moroney & Kurtz, 1975).

A hospital based medical practice was also more profitable because the doctor could see more patients in less time. To these benefits were added the suitability of

the hospital for the increasingly technical procedures that physicians used (surgery in particular), and the prestige of being associated with these "cutting edge" institutions (a phrase reminiscent of the technology) (Ashley, 1976; Vogel, 1979).

Other important elements in the establishment of medicine's professional status during this time was the aggressive stance of its primary membership organization, the American Medical Association (AMA) and the powerful changes that occurred in the field of medical education. The AMA pushed constantly for medical licensure that would separate properly prepared physicians from other groups that styled themselves as doctors. In the process it encouraged the increased formalization of educational and training regimens. The Flexner Report, published in 1910, is often mentioned as the turning point in medical education and prestige. The report criticized then current variations in medical education and presented a detailed description of what a medical education should contain. Though scientific progress in medicine during this time was also important, these changes in medical education are credited with providing the impetus for the rise in status that medicine achieved. This success helped medicine to become the dominant health care profession (Bullough, 1980; Hanft, 1981; Kalisch & Kalisch, 1986; Moroney & Kurtz, 1975; Rogers, 1986; Starr, 1982).

Modern Nursing Emerges

However dramatic the consolidation of authority and prestige by medicine in the era between the 1850s and the 1930s, the advances and changes in nursing may have been greater. Nursing histories frequently focus much of their attention on the remarkable career of Florence Nightingale, whose most renowned exploits occurred in the Crimean War. In an unprecedented approach, she went to the scene of the conflict and administered to the sick and wounded of the British army using the tools of sanitation, hygiene and professional caring that may still be the hallmarks of nursing. She had to fight against precedent, against the ignorance of the military, and of military physicians, and against powerful prejudices regarding her sex. She prevailed through her force of will, intelligence and concern. Both her success in treating military cases and her elemental humanity made her the leader of the nursing profession. The work of Nightingale and her nurses at the Barrack Hospital of Scutari were legend in their own day; the stories and dispatches from that time reached all England and the world. They are still referred to in nursing texts and classrooms more than a century later (Dolan, 1978; Kalisch & Kalisch, 1986).

However dramatic a figure Nightingale was, it was the value of nursing technique, including cleanliness, demonstrated at Scutari that transformed nursing.

Nightingale subsequently published books and monographs on reforming the care of soldiers, nurses' training, sanitation in Indian villages, and other nursing topics. She began nursing schools and led her profession into its modern era (Dolan, 1978; Kalisch & Kalisch, 1986). The experiences of Clara Barton and her colleagues in the United States Civil War paralleled and were informed by the experiences of Nightingale. One outcome of Barton's work was the United States Sanitary Commission which led to the use of sanitary technology and good hygiene to improve the public health of the United States, applying techniques that came out of the military nursing experience. Without these techniques, pestilence would have been much more widespread in the United States and the progress of modern surgery and medicine would likely have been slowed (Kalisch and Kalisch, 1986).

Women were central to the development of nursing. Most nurses were women and most nurses still are. In some cases by implication (Dock & Stewart, 1938) and in other instances quite explicitly (Ashley, 1976; Dolan, 1978; Melosh, 1982; Reverby, 1987), nursing historians describe the importance of a women's place or a women's role in the development of the profession of nursing. A women's place often meant negative discrimination based on nurses' predominantly female sex and by extension, the profession's female gender. The conscious subordination of female nursing by male

medicine throughout most of their contacts made the rapid rise of nursing in this period even more remarkable.

Partially because of the hard won respect for nurses like Clara Barton, the need for better prepared nurses and for hospitals to be clean places of care giving had become clear; thus nursing education began to grow rapidly following the Civil War.

In Boston, Susan Dimock, M.D., headed the Training School of the New England Hospital to prepare nursing students to assist physicians and to provide patient care in a hospital setting. Opened in 1872, the school produced the first nurses certified to have completed a specific program of training in the United States. It was a one year course. The following year other, similar schools opened, including one at Massachusetts General Hospital. More were opened in subsequent years. Many were based on the model proposed by Florence Nightingale (Ashley, 1976; Dock & Stewart, 1938; Dolan, 1978; Kalisch & Kalisch, 1986).

The Growth of the Hospital

The hospital would become the model health care organization of the twentieth century. It has had great influence on the development of modern nursing homes. In the late nineteenth century hospitals were proliferating. It has been estimated that in 1873 there were 178 hospitals in the United States; by 1909, the number had reached an estimated 4,359 (Enright & Jonas, 1981) and hospitals were

commonly available in United States cities. Some were privately owned and some were public institutions. Hospitals like New York Hospital and the Massachusetts General Hospital maintained separate, more comfortable facilities for the well to do and influential. Others, such as Bellevue Hospital in New York and Boston City Hospital, focused on the needs of the more general population.

Most hospitals were charitable organizations, privately owned and financially dependent on contributions, augmented by whatever income they might derive from operations. They were staffed with nurses and dominated by physicians. Originally they had been entirely charitable institutions; places that cared for the poor and allowed physicians to perform the experiments of scientific medicine on their patients. When the success of the "experiments" had become routine and those who could pay became the patients, costs shot up and doctors' practices shifted from their offices to the hospital (Vogel, 1979).

From that day to this, hospitals have been the quintessential United States health care institution. The dominance of hospitals in the health care system has contributed to the characteristics that nursing homes have today (Jonas, 1981; Dock & Stewart, 1938). The development of these institutions from almshouse or quarantine site to hospital, from sink hole of disease to site of medical

discovery, has encouraged the development of nursing homes along similar lines.

Education was an important element in the development of nursing. The nursing profession grew with hospitals. In 1873, there were reported to be three training schools for nurses; by 1900 there were 432 and by 1910 1,129. (Starr, 1982; Vogel, 1979). More than education drove these developments, the labor of student nurses was important to the hospitals.

Schools of nursing sometimes abused their students by extending the time they had to spend doing unpaid nursing work in hospitals during their training. Further, so many nurses were accepted into schools and succeeded in these programs that there were sometimes few paying jobs available for them when they completed their arduous period of training (Ashley, 1976; Melosh, 1982; Reverby, 1987).

Nonetheless, the profession of nursing grew and became more important to society. Nurses worked in hospitals, but they also worked in public health, in social welfare, in the military, and in what we know today as home care or visiting nurse roles. Private duty, in which nurses worked as self-employed professionals, was the dominant work situation of fully trained nurses through at least the 1920s. They were often advocates for the sick and disabled and frequently were prominent in social reform movements.

As the medical profession progressed, nursing shared in its scientific and technical accomplishments. By 1930, many states had nurse licensing boards; nursing education was well established; nursing journals had been published for some time; academic nurses did some research; and the modern profession was established. Despite the gender prejudice it faced and with the assistance of medicine in some areas, nursing had propelled itself from its very limited role in 1850 to become a cornerstone of health care in the United States.

The development of the hospital as an institution to serve physicians, train and employ nurses, that was run by male administrators may have had an important effect on the development of nursing homes. As hospitals grew, the nursing staff and the schools that supplied them grew. By the turn of the century, the superintendent of some hospital's nursing school and nursing service also became the superintendent of the hospital itself. This ascendancy of a senior nurse to chief administrator was short lived. Hospital administrators quickly emerged as male authority figures in this role. By 1908 the American Hospital Association (made up largely of male administrators) considered resolutions to oppose the more thorough training of nurses. College or university based teaching programs, single status licensing, and licensing for more independent practice by nurses have all been opposed over the years by

male colleagues' organizations like AHA and AMA (Ashley, 1976; Melosh, 1982; Reverby, 1987; Reverby & Rosner, 1979; Starr, 1982; Vogel, 1979, 1980).

While many early, small nursing homes were run by women nurses, the more common model has placed authority in a male businessman, the administrator. Clinical matters are usually guided by male doctors. Nurses are made subordinate to each of these characteristically male professions.

Care of the Elderly

During the nineteenth century, the population of the United States changed in many ways. It spread west and south and it included an ever increasing number of recent immigrants. The population not only grew much larger but that the proportion of older people increased, and lived even longer. As noted earlier, in 1820 about 15 percent of men and 17 percent of women in Massachusetts were over age 45 years. By 1860, almost 15 percent of women and 12.6 percent of men were over age 50 and a significant number were over 60 (7 percent of women and 6 percent of men). In 1820, the total Massachusetts population had been just over 300,000 people. By 1860, it was 1,231,066 persons; about a 40 percent increase over a 40 year period. By 1930, the Massachusetts population reached 4,249,614. About 6.5 percent were over 65 and more than 26 percent were over 45 years of age (United States Census; Linford, 1949).

The point is clear. People lived longer in 1930 than in 1820 and there were many more who would have been considered "old" at the earlier date.

Looking back from the latter part of the twentieth century, we may think of almshouses and the old English poor laws as being of the same, early era. But in the United States, the almshouses continued well into this century. Some changes did occur. The creation of specialized institutions for other classes of needy people, as a result of late nineteenth century reform efforts, left the old as the predominant group in almshouses. One report states that the percentage of old people in almshouses rose from 33 percent in 1880 to 67 percent in 1923 (Haber and Gratton, 1994). The same authors report that the names of almshouses were changed to reflect their new mission. For instance, the New York City Almshouse was renamed the "Home for the Aged," and efforts to demand work from its residents were reduced or eliminated. Although county homes and public homes for the aged continued much as almshouses had in the past, with politically appointed administrators housing large populations with their focus on keeping costs low (Drake, 1958), the progressive era of the early twentieth century began to bring changes.

Charitable Organization Societies

One history describes the progressive era as a time when the forces of government were brought to bear on social

situations which required new approaches as a result of the industrial era (Morison, 1965).

The progressive era was predated by a movement that included the Charity Organization Societies. Started in the late nineteenth century on the model of English social theorist, Thomas Chalmers, these societies joined middle class industrialists and businessmen with religious and political leaders to bring "wisdom" to the unfortunate dependents of society by visiting with them in their institutions. These civic leaders soon realized that the individuals or families they were visiting had come on hard times not through weakness and sloth (as had been supposed), but rather as a by-product of an industrially organized society (Friedlander, 1955).

The Charitable Organization Societies were influential in the reform movement. They called for the development of private or voluntary (not tax funded) homes for the needy aged who had depended on public almshouses for shelter, in part to stamp out the stigma of pauperism and in part to provide more adequately for these people's needs (Moroney and Kurtz, 1975). Their efforts and influence led to an expansion in the number of boarding homes and an increasing public awareness of the need for reform in the almshouse system (Lidz, et al, 1992; Vladeck, 1980). By 1920, about the same number of older people lived in public almshouses as lived in charitable, private homes for the aged: about

50,000 in each type of facility (Johnson & Grant, 1985). This represents a massive change from the situation in the nineteenth century.

The Charitable Organization Societies had attempted to provide improved, voluntary institutions for the old and disabled as well as outdoor relief or home based services. As society became more industrialized, mobile and urban, some boarding houses became boarding "homes," which made greater accommodation for disability and illness; sometimes they would arrange private duty nursing. As these boarding homes provided more and more care, they sometimes developed into convalescent homes. However, as it happened, they were mostly proprietary establishments and could be expensive, even for a person with some funds (Pearson & Wetle, 1981; Vladeck, 1980).

The charitable homes for the aged became a focus of fraternal and civic groups as the fear of the "almshouse," "poorhouse," old people's home," or "infirmary" (where health care was being offered in almshouse like settings) grew (Haber, 1983). People throughout society were beginning to realize that poverty might strike anyone in old age. In Boston, charitable facilities were targeted for those of appropriate ethnic background and particularly for women. Recent immigrants and "wastrels" were still to use the poor house or infirmary.

In the absence of any rehabilitative rationale or especially trained, professional leadership, the almshouse continued to flounder as an institution. Overcrowded and inhumane, the state almshouses, county homes, and town poorhouses were racked by corruption and disease. Writing about inmates of such facilities Rothman reported, "They lived in decrepit buildings, with meager provisions, under keepers who were more guilty of neglect than cruelty" (Rothman, 1971, p. 202). Despite their inhumanity, most recorded discussion concerning almshouses still was related to how cheaply they could be run (Rothman, 1971). Toward the end of the nineteenth century, almshouses were so bad in Massachusetts that Governor Butler sent a formal message to the legislature demanding that it provide proper support for the state almshouse. The previous year's allotment was insufficient. Butler ordered the Board of Lunacy and Charity to take over the running of the institution. At first the board refused. "I have assured the Board that until proper time for legislative or other action in this behalf, I will personally see to it that the money shall be forthcoming....," said Butler. This personal promise was apparently necessary to get the Board to accept responsibility for the facility at all (Butler, 1883, p.1-2).

By the end of the nineteenth century the almshouse had been discredited and so had public care for the old and

sick. Medicine was beginning to dominate health care. Nursing developed both in hospitals and in the community. The new hospitals were privately owned and organized. Only penitentiaries and the huge mental health hospitals, stigmatized by their very missions, were left to the public sector. Health care, including care for the old, disabled, and sick would not be entrusted to the public sector again, except under special circumstances. The nursing home, largely a twentieth century phenomenon, would be privately owned and operated because of the failure of the almshouse. Weisbrod's explanation that government would be a natural provider of health care because 1) it had no profit motive to cheat people, and 2) because it had broad authority to raise revenues through taxation, did not quite work out. A century of failure in the provision of housing and care in the almshouse would poison popular opinion on the topic of publicly provided, residential health services for generations to come.

In this chapter the nature of care for the old and sick from the colonial era to the beginning of the twentieth century is briefly examined. Medicine and nursing were marginal activities at the beginning of this period. Almshouses and poorhouses developed as populations grew and "outdoor relief" was perceived to be expensive and inefficient. These early institutions and their successors were never adequate and often feared.

Meanwhile, medicine consolidated its position in health care during the latter part of the nineteenth century, nursing emerged as a profession with its own schools and leaders, and hospitals began to develop as places of curative practice. By the beginning of the twentieth century schools of medicine and nursing were becoming well organized and hospitals were the center of modern health care. Most of the schools and hospitals were private organizations and many were nonprofit.

The successes of these private professions and institutions were in direct contrast to the publicly owned almshouses and asylums. The public was beginning to realize that it cost more to take care of people who were poor, but responsible, in the poor house than it would cost to give them an allowance and let them look after themselves (Haber & Gratton, 1994). In essence, this was an argument for a return to outdoor relief, a complete denial of the 1821 report of Josiah Quincy. It is the most obvious indication that the public provision of residential and health services for the old and poor was rejected by the people who had once supported it. The public system of care had failed.

CHAPTER 2

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CHAPTER 3
OLD AGE ASSISTANCE FROM THE ALMSHOUSE TO THE FIRST STATE
PROGRAMS

This chapter reviews economic and social programs from the late 19th century to the time immediately preceding passage of the Social Security Acts. As almshouses came under greater public scrutiny, public entities moved away from the care of poor elderly in large institutions toward providing economic supports which permitted them to care for themselves. In this chapter we see that large, organized nursing homes, at first, were related to nonprofit ownership. This is much in keeping with Weisbrod's theory that nonprofits should benefit from public trust in matters as complex and difficult to monitor as personal care and nursing services.

The Progressive era (roughly 1900-1918) was a time when many thought that government could help strengthen and improve society. Some innovative public policy efforts were begun in this era. A successful effort to establish workman's compensation led to a similar attempt to establish old age assistance at the state level. There was an aggressive movement for universal health care coverage. The effort to establish old age assistance eventually succeeded, with many state programs in place by 1930. As this movement

grew, it laid much of the groundwork for the first Social Security Acts of the mid-thirties. This chapter describes how old age assistance led to the expansion of boarding homes where older people could pay for their room, board, and, if needed, care. Like the homes for the aged, these facilities were precursors of modern nursing homes. Like the modern nursing home industry, these smaller care facilities expanded as government assistance provided their customers with the means to buy services.

The Almshouse in the Twentieth Century

Although the almshouse may seem an artifact of the distant past, it continued as an important source of old age services well into the twentieth century. The Bureau of Labor Statistics found that in 1923 and 1924 more than 2,183 almshouses in 48 states were sheltering over 85,889 people (Bureau of Labor Statistics, 1929). The conditions ranged from relative comfort to desperate squalor. The sick and well lived together and few inmates were constrained from leaving if they wished.

New York State enacted the Public Welfare Law of 1929, supplanting the 1824 law that had strongly favored "indoor relief"; meaning, the almshouse. The 1929 law was geared to "outdoor relief"; meaning, support in the community. Expenditure of public funds in the community rather than in the almshouse provided the financial support for the increased growth of proprietary nursing homes in that state

(Thomas, 1969). Since people who had once depended on the almshouse now received financial support in the community, they could use that money to purchase nursing home services.

The cost of caring for paupers, or persons in almshouses, was a constant concern for taxpayers of that day, just as the cost of maintaining a social safety net is a concern today. The 1923-1924 Bureau of Labor Statistics study was published, in part, as "The Cost of American Almshouses." Outdoor relief had been rejected in the early nineteenth century as too pleasant (Haber, 1983). During the early twentieth century some felt that a return to outdoor relief might be cheaper. In the preface to "The Cost of American Almshouses", Estelle Stewart noted that outdoor relief, in the form of cash grants to needy individuals and families, was gaining favor; while indoor relief, as represented by the almshouse or poorhouse, was less common and almost unknown. Stewart tells of a woman who lived in a town that had a state almshouse, yet she knew nothing of it until she became the head nurse there. She also tells the story of a social worker who thought that almshouses were ugly creatures of the past, until he became the state inspector of public institutions. The lesson is that the almshouse was alive but, like a contagious disease or a wastrel sibling, it was hidden and unmentionable. By the early twenties almshouses had become so ridden with bureaucracy and politics that they were no longer

inexpensive (Stewart, 1925). One estimate put the poorhouse population of New York state at 85,500 in 1900 (Berkowitz, 1991). In 1924 there were only about 86,000 people left in almshouses throughout the United States (Bureau of Labor Statistics, 1929).

Examination of the 1929 BLS report illuminates the condition and character of almshouses in 1923 and 1924. Most were run by states and counties. The states oversaw the counties' operation of the facilities and reported on the quality, cost, productivity, inmate census and extent of the facilities. A number of facilities were reported to be vacant, but, like those which still had inmates, their expense, income, total acreage, farm equipment, and acreage under cultivation were reported. Quality was reported as physical and social conditions (Stewart, 1925). The report presented almshouses as some combination of business enterprises, pork barrel public works projects, and social institutions. That a number were vacant and that only 86,000 odd souls were reported to be in residence nationally is an indication of their approaching demise.

The negative reputation of these facilities was so forceful it made them secrets in their own time and made the terms almshouse and poorhouse epithets for institutional inadequacy. For instance, The Poor House State is a volume critical of public assistance as provided in the middle of the 20th century. The author focused on the short-

sightedness of a welfare system which many viewed as punitive and demeaning (Elman, 1966).

In 1929, the Bureau of Labor Statistics said "The result is that the almshouses of New England more nearly fulfill the real purpose of an almshouse - that of providing refuge and care and a fair degree of comfort to the old and infirm - than those of any other section of the country" (BLS, 1929). However, the preface to a 1925 bulletin characterizes the early reputation of the almshouse differently: "To older generations the almshouse, or poorhouse, was a very real thing. As has been said, they were brought up with 'a reverence for God, the hope of heaven, and fear of the poorhouse'." (Stewart, 1925).

In their chapter entitled, "The Threat of the Almshouse," Haber and Gratton describe the harsh reality of almshouses in an earlier day. They describe improvements and concerns which emerged in the twentieth century as society rejected the role of almshouses as "deterrents to the presumed laziness of the foreign born and vicious," and moved to "'fulfill the real purpose of an almshouse - that of providing [for] the old and infirm'." (Haber & Gratton, 1994, p.124). The authors argue that the development of the private home for the elderly was a direct response by society to the squalor and deprivation of the publicly operated almshouse.

It was in the almshouse that the connection between the residential needs of the elderly and their medical needs converged. In Boston the need for ongoing medical care in the almshouse was stated in 1903 by the visiting medical staff of the Long Island Almshouse and Hospital of Massachusetts (Haber, 1983).

Homes for the Aged

In its "Care of Aged Persons in the United States, Bulletin 489" the Bureau of Labor Statistics details who cared for the aged in 1923. This federal study identified 1,270 homes for the aged in the United States. Of these 1,037 provided information included in the study. Nine were federal homes, 46 were state homes, 102 were fraternal homes, 444 were homes maintained by religious organizations, 38 sponsored by miscellaneous organizations, 33 were sponsored by nationality groups, 5 were trade union homes, and 360 were privately owned homes. Thus 360 were proprietary, 622 voluntary and 55 government owned. They provided for a reported 68,659 persons. Various restrictions applied. Some took only men or only women, and some required that residents be 60 years or 65 years old. Membership in the sponsoring group was often required. Respectability and/or good moral character was often specified as a requirement for admission. Most of these facilities were located in urban and industrial areas,

presumably because such places had a population that needed them and the wealth to support them (BLS, 1929).

The private sector predominated in providing homes for the aged (982 of 1037 homes surveyed). In part, this is due to the fact that county homes were viewed as part of the almshouse or poorhouse system rather than as homes for the aged. It was also because these homes for the aged were intentionally developed to avoid public care and the failure it represented.

Other differences between almshouses and homes for the aged were that the latter sometimes required payment by residents (referred to as "inmates" by the report) while almshouses were free. Furthermore, homes for the aged were usually in urban areas, while almshouses or poor farms were often agrarian and in rural settings.

Many of these homes had been in existence for at least half a century, but both their capacity and their number had grown dramatically in the 20th century. About two-thirds were between ten and 50 years old.

Rules and regulations for residents were pervasive in homes for the aged. Some required that able bodied residents help with chores. The rules of the home had to be obeyed and some had probationary periods for new residents. More than 90 percent of the facilities provided medical and nursing services, much as the nursing homes of today do. Both dormitory and ward arrangements were used for sleeping,

although a few had private or semi-private rooms. Often there were large dining rooms, sitting rooms and libraries. Large verandahs were also popular. However, physical plants varied, and some were simply converted private residences that would offer few such amenities. By contrast with today, with 1200 nationally, these homes were few in number. New York State had 24, Massachusetts 21, Texas had 22, but Wisconsin with its strong religious and ethnic base had 31. Connecticut with one, Florida with two, and Maryland with five were much nearer the national norm. By comparison, today there are nearly 600 nursing homes in Massachusetts alone, with a capacity of about 50,000 beds.

The federal government facilities were limited to Soldiers and Sailors Homes, and so were all but two or three of the state facilities. Homes for the aged owned by labor organizations were large and well appointed. Like some of the others, these facilities had been established to care for those who did not have the funds or circumstances to look after themselves.

The Bureau of Labor Statistics found that in 1923-1924, 526 homes for the aged were run by religious organizations. Information was collected on 444, 224 of which had been in existence for at least 25 years and 77 for 50 years. Some of these were national facilities, but most were operated by some narrower portion of its sect, including individual parishes. The dominant feature of these religious homes may

have been their relatively small size. Some 30 percent sheltered fewer than 25 people and 57 percent accommodated fewer than 50 people. However, 22 Catholic homes and five Jewish homes had capacities in excess of 200 people. The average size was 67 beds. Admissions and operating arrangements were highly variable, but it was not unusual for residents to pay for their stay or some portion of it. Philanthropy, however, was a major source of operating funds for these facilities. Homes owned by religious organizations made up the largest category of privately run homes for the aged (BLS, 1929).

The 102 homes run by fraternal organizations in many ways were similar to those sponsored by religious groups. One major difference was that the facilities sponsored by fraternal organizations were national in scope and many were large. But the similarities far outweigh the differences. A number of fraternal facilities were smaller in size, supported by philanthropy or dues as well as by payment for services, most had been in existence since the turn of the century, and most were independent of their sister facilities.

The second largest category of old age homes were those privately run by benevolent institutions, of which 360 were listed in 38 states. The majority had fewer than 50 beds, with only 19 reported to have more than 100 beds. About 78 percent had begun operations in the previous 50 years. Most

seem to have been established through non-denominational philanthropic efforts and many had specific admission standards and categories, such as sailors or widows over 65 years. Often there were admission and other fees for those who had funds, but some facilities were for the indigent. Few homes surveyed for this report absolutely required payment. The average per capita cost, which was a little more than \$400 per person, was consistent with other types of facilities (BLS, 1929)

In summary, the 1929 BLS report describes a set of about 1200 homes that provided medical and nursing care and had many other qualities we associate today with nursing homes. Yet, in important ways, nursing homes as we know them did not exist at that time. Today's nursing homes are often privately owned by individuals or corporations and are run as businesses, they exist in great numbers, and are relatively large. Today organizations of homes for the aged are often groups of not-for-profit facilities (as in the Association of Massachusetts Services and Homes for the Aged, AMSHA). In 1923-24 Homes for the Aged had been around for more than 50 years, but there still were very few facilities.

Social Insurance Schemes

Two social and political struggles pertinent to the development of nursing homes were prominent during the first decade of the twentieth century. One was a conflict over

old age assistance and economic security. The other was the argument over the provision of health services; should everyone have access to decent health care through some government mechanism? Although neither issue developed, narrowly, as a nursing home issue, both became very much involved in the rapid and explosive growth of nursing homes later in the century. They also reflected altered approaches to social welfare in the United States from which nursing homes benefitted. In this sense they laid the ground work for a political culture that would accept Social Security in the 1930s and the Hill-Burton act in the 1940s.

Health Insurance

In discussing the movement for universal medical insurance, it is important to remember that this was both a health and an economic issue. If everyone could afford to pay for services, the argument for a universal system of services or insurance would be much reduced. However, in the early part of this century, as the usefulness of health care was becoming well recognized, the cost was a great concern to many people. One social scientist refers to a 1918 study which showed that a doctor's visit might cost \$2.00 or \$3.00 at a time when \$14 a week was enough to feed, cloth, house and otherwise maintain a large family (Numbers, 1978). The cost of basic health care was a major factor in the fear of sickness.

In the waning days of the Progressive Era the American Association for Labor Legislation (AALL) took up the cause of universal health insurance (Starr, 1982; Hirshfield, 1970). Fraternal orders and labor organizations sometimes offered some sort of health insurance benefit, but most working people lacked coverage and many did without physician and hospital services. Government involvement in health care occurred most frequently at the local level and was sparse; in fact, the almshouse and outdoor relief were viewed by some as health services (Numbers, 1978). This was in direct contrast to the situation in Europe, where Germany had led the way to compulsory health insurance in 1888 and was followed by a half dozen other countries, including England.

The AALL had success in campaigning for workman's compensation and an end to certain hazardous uses of phosphorous when it chose to take on social insurance in 1912 (Numbers, 1978; Starr, 1982). The AALL focused its efforts on state governments to achieve passage of social health insurance, in a strategy similar to its successful campaign for workman's compensation insurance. It argued that a social health insurance scheme had economic and social benefits for government, for industry and for individual workers. As a preliminary effort, the AALL planned to educate interested and influential individuals and groups nationally and state by state. By the summer of

1914, the AALL's Committee on Social Insurance had enunciated a nine point program that could be the basis for compulsory health insurance legislation in the states. The Committee was made up largely of academics, although one member was the noted actuary and Prudential Insurance Company employee, Frederick Hoffman. One of the nine points was to include a death benefit in the program; Hoffman resigned over what was seen as a threat to commercial insurance companies' very large business of selling small death benefit policies (Numbers, 1978; Hirshfield, 1970).

As the Committee's effort went forward, government officials became favorably disposed toward the AALL program. Similar European programs were evaluated. Both organized labor (with the exception of Samuel Gompers) and physicians (including the American Medical Association [AMA]) expressed support for the program. By 1917, a model bill was being circulated to interested parties, including state legislatures, and the expectation of success was building (Numbers, 1978; Hirshfield, 1970; Starr, 1982).

The Health Insurance Effort Fails

This first major effort at developing publicly organized, mandatory social insurance failed. To this day, there are very few such programs in the United States and they are of recent origin (the State of Hawaii program, for instance). The apparent causes for the failure of this initial drive for social health insurance will seem

familiar. There was some divisiveness amongst supporters. Gompers disaffection, for example, was important for labor. Gompers felt that the offer of health benefits was an organizing tool that unions should not give away to the government; nor did he wish to have workers taxed further (Hirshfield, 1970).

Frederick Hoffman became an aggressive enemy of the health insurance initiative, largely because of its negative effects on the insurance industry. Ironically, the German-born Hoffman had also been one of the first to denounce the idea as foreign to the United States. Hoffman and his allies criticized the program in any way possible and were influential in its demise (Hirshfield, 1970; Numbers, 1978; Starr, 1982).

A modern observer might overlook the importance of the 18 month involvement of the United States in World War I. However, roughly 25 per cent of the nation's physicians served in the military during that time, mobilization was extensive, and it changed the country. Even physicians who had studied in Germany and had admired its culture and science became anti-German isolationists. Things European became tainted and corrupt in the eyes of the populace and social insurance programs became easy targets for criticism in this context. Social programs were also painted red with the blood and chaos of the Russian Revolution. Anti-German, anti-Communist, anti-European isolationism was rife and

colored these and subsequent debates for social insurance (Numbers, 1978).

Prosperity and materialism found a new life in the 1920s in the United States, which helped to bring candor about personal financial issues to the debate. Physicians not only argued for the qualities of American independence, they also argued for fair payment while expressing concern that social insurance would cause medicine to be driven by dollars. Although not consistent in some ways, these dual arguments caused the AMA and physicians in general to alter their positions, moving away from tolerance or support of social programs. Coalitions of support for the social insurance scheme began to show fissures and weaknesses. As early as 1920 it was clear to many that the effort had failed (Hirshfield, 1970).

For the purposes of the present study of nursing homes, one of the most important qualities of the social insurance effort is that it was an attempt to extend the scope of public responsibility to include health care. That attempt was forcefully denied. It was denied despite the fact that, in the proposed program, physicians might have made more money and cared for more patients; it was denied even though workers would have had better health care at little or no additional cost; it was denied although business might have realized a net economic benefit from it. To a large extent it seems to have been rejected because it was a public and

compulsory effort. What little health insurance was available continued to come from private, largely not-for-profit entities, just as homes for the aged continued to be run by private, largely not-for-profit entities. These events had repercussions that put off social development in health care for decades to come.

The health insurance movement's failure was important for medicine, hospitals and nursing homes in the United States. If extensive public ownership of health facilities was to survive the failure of the almshouse, it might have developed through government health insurance and services developed on a social model. Instead, facilities and services continued to develop on private models after social models were discredited as foreign and distasteful. The focus shifted to issues of poverty and equity.

Old Age Assistance

Reformers of the Progressive Era not only denounced the cruelty of the almshouse and championed social insurance for health services, they also saw a need for universal assistance for the old and needy. The fight for old age assistance at the state and federal levels was the most powerful antecedent of Social Security from this era. The thinking behind and the development of old age assistance is of interest here because it led to the distribution of moderate sums of money to older citizens. This moderate improvement in economic status gave elders the funds to

support themselves in boarding houses, boarding homes and, eventually, nursing homes in unprecedented numbers.

As we have seen, states and localities had various ways of providing for the indigent aged. Some states increased the legal responsibilities of family members and some increased outdoor relief in the form of food, clothing, fuel, and the like. Some continued to use indoor relief in the form of almshouses or county homes (Drake, 1958).

Support for needy elders in the form of public and private pensions was not well developed (Haber, 1983). Particularly during the Progressive era, reformers sought better solutions to the care of the elderly poor. An old age assistance program offered a prospective solution. The logic was simple: if older people are poor because they do not have enough money, give them money.

By 1929, ten states and the territory of Alaska had old age assistance laws that shared some characteristics: they all made monthly payments to poor elders who met residency requirements and whose families could not support them. The first law was passed in 1915 (Drake, 1958). These laws permitted counties to provide old age assistance. But only Wisconsin and Minnesota provided funds to the counties for such expenditures in the early days of old age assistance. The stock market crash of 1929 and the subsequent economic depression led to increases in the number and size of old age assistance programs. By 1934, 28 states and two

territories had such laws. It became more common for county participation to be mandatory, which increased the number and percentage of old people covered by the laws (Drake, 1958; Linford, 1949).

Massachusetts was one of the first states to consider old age assistance. It appointed a committee to study the question in 1907, but there was no immediate response to the report. In fact, old age assistance or public old age pensions (much the same thing) were a subject of political jousting and controversy for many years in many places. Both passage and repeal occurred in Nevada, and in Pennsylvania one such law was found to be unconstitutional because it made contributions to benevolent societies (Bureau of Labor Statistics, 1929). Massachusetts finally passed an old age assistance law in 1928.

Critics of the early old age assistance or old age pension laws made several points. The purpose of the old age pension was for people to live their last years in self-respect and safety. But in this non-contributory system, the similarity to poor relief was evident and was thought to reduce self-respect and self-reliance. Critics feared the expense of such programs and also feared their growth as more individuals and families became dependent on public funds for support (Bureau of Labor Statistics, 1929). From today's viewpoint, the most striking characteristic of these plans is that, in many states, the amount and availability

of funds varied from county to county. (Drake, 1958; Bureau of Labor Statistics, 1929).

One State's Experience

Alton Linford's study, Old Age Assistance in Massachusetts, provides a more detailed picture of the developments in one state. Linford notes that while the modern term, "old age assistance," is used in his study, public payments for the needy elderly for many years had been termed, almost exclusively, "old age pensions." In this study, the terms will be used interchangeably. From 1903 to 1928, every session of the Massachusetts legislature considered bills for old age assistance, and four study commissions reported on it. As others have done, Linford suggests that the need for old age assistance was related to industrialization and urbanization. When old age assistance finally passed into law in Massachusetts, its purpose was somewhat different from the poor relief it replaced. Poor relief, usually the almshouse, was designed to be undesirable to deter people from using it. When the Massachusetts old age assistance law took effect in 1930, its eligibility requirements reflected a more generous intent (Achenbaum, 1986; Drake, 1958; Derthick, 1970; Haber, 1983; Linford, 1949).

Old age assistance was mandatory for every jurisdiction in the Commonwealth. Its standards of eligibility were not so stringent as those of poor relief, and it offered a

monthly cash benefit designed to provide adequate assistance. In addition, the Commonwealth monitored its administration. Another major difference from poor relief was that recipients were permitted to retain some real estate and other assets while receiving benefits.

Setting the age for eligibility was a ticklish issue, because both the economic cycle and gender were felt to have a bearing on need. As a result, women became eligible at 65, five years earlier than the men to whom they were presumed to be married, and the various bills filed in Massachusetts over the years had eligibility criteria that ranged from 60 to 70 years for men. Age criteria were finally set at 70 years for men, primarily to limit the cost of the program. Each year, from 1930 through 1935, major legislative debate focused on the desirability and cost of reducing the age of eligibility for men from 70 to 65 and for women from 65 to 60. In 1936, with federal funds available from the Social Security Acts, the reduction to age 65 for men was made, despite the fact that the federal legislation would have permitted the age of eligibility to remain at 70 years (Linford, 1949).

United States citizenship, residence, and settlement requirements were attached to eligibility. Twenty years of residence immediately prior to application was required. These settlement and citizenship qualifications were

reminiscent of earlier relief provisions that favored native born and stable members of the community.

Just where services and care were to be provided under old age assistance in Massachusetts was not clear in the original legislation. The statute says that relief and support should be supplied to the aged "in his home or in lodgings or in a boarding home" and should be sufficient to provide "suitable and dignified care" (Massachusetts General Laws, 1930). This language also was used by some towns and cities as a basis for providing some level of medical care. Obviously, it is also language that might be used to provide personal care and nursing services in a residential setting.

Linford's study does not examine the use of old age assistance to support people in homes for the aged, rather, it implies that care was received in boarding homes. Boarding homes were privately owned, for profit operations that prefigured what has become the nursing home industry. These private boarding homes were much more numerous than were homes for the aged and were much smaller.

These events of the early twentieth century, especially the old age assistance movement in the states, were forerunners of federal Social Security. Social Security is the program that has had the greatest impact on the economic status of older citizens of the United States in this century.

The development of old age assistance in the states also provided indirect financial support to numerous, small boarding homes that provided some level of nursing and personal care. Although the development of these early, private nursing homes is not well documented, they began to become more common at this time. In terms of Weisbrod's model, they developed because there was a market for their services. Since nursing and personal care services are among those which Weisbrod would expect to require greater reliance by customers (family members of those served in this case), it is counter to his thinking that a for-profit model should prosper (Weisbrod, 1988).

Of course, these early for-profit enterprises were not the large nursing homes of today that are run by national conglomerates. It also seems unlikely that they offered the wide array of sophisticated services that modern skilled nursing facilities provide. Rather, they probably were large houses, owned and run by nurses who offered nursing care to a handful of residents in a very direct way.

The almshouse continued into the twentieth century, but had been rejected by society and was viewed as an unfortunate relic of the past. Reformers moved toward "outdoor relief" and old age assistance. A 1929 federal government report described homes for the aged, both proprietary and nonprofit as they then existed. There were important similarities to today's nursing homes, but the

number of facilities was quite small at 1200 homes. Not counted in this group were the increasing but unknown number of small, privately owned boarding houses with nursing care.

From the early days of the century reformers supported social insurance schemes for health insurance and old age assistance. The AAAL tried to build on its base of success with workman's compensation to promote a European style social health insurance program on a state by state basis. The First World War had disastrous consequences for this organizing effort, which failed by the early 1920s. The old age assistance efforts were more successful, if less well organized. Most states had old age assistance programs by 1930s; but they differed greatly and were often limited in scope. With regard to nursing homes, the importance of these reform efforts is that they helped to establish a political culture that would accept first Social Security in 1935, then federal assistance in the construction of health facilities in 1947, and Medicare and Medicaid in 1965.

CHAPTER 3

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CHAPTER 4

THE PATH OF SOCIAL SECURITY: THE THIRTIES THROUGH THE FIFTIES

This chapter briefly reviews the events leading up to the passage of the original Social Security Acts in 1935 and the organization of the Committee for Economic Security. The passage of Social Security and the language of the first Acts provided a tremendous stimulus for private nursing home development. The chapter describes the arrangements for boarding homes and nursing services for the poor in Boston in the early 1940s. This was a time of relative economic prosperity for elders because of the Social Security Acts and because of the war effort. Chapter 4 also discusses the continuing effort to pass universal health coverage in the United States, and the availability of Hill-Burton funds and FHA loan guarantees for the construction of nursing homes. The movement for universal health coverage was largely denied, but national attention was focused on facility problems through Hill-Burton and FHA guarantees. These federal efforts were major public policy initiatives designed to expand health care facilities, including both nonprofit and proprietary nursing homes. Chapter 4 shows how public programs and social changes brought a rapid increase in the number of nursing homes in the country and

begins to show why more of the new beds and new facilities were built by for-profit organizations rather than nonprofits.

Old Age Assistance

By 1930, government support of the aged had taken on the rhetoric of old age assistance for the poor elderly and pensions for those who earned them through service or savings. As noted in Chapter 3, such concepts were not new. In fact, in 1889 and 1890, the United States had major obligations for pension payments. One source estimates that 27 percent of 1889 federal expenditures were earmarked for pension payments (Quadagno, 1988); most of these payments were to soldiers (Achenbaum, 1986; Haber and Gratton, 1994; Quadagno, 1988). Chapter 3 also describes the decades long policy debates over social insurance issues concerning older citizens. Although many states offered some sort of old age assistance by 1930, few made such assistance mandatory for every county, and the cost of the programs was a matter for concern (Weaver, 1982). Both labor and management organizations opposed social insurance schemes (Achenbaum, 1986; Lubove, 1968; Quadagno, 1988; Weaver, 1982).

The Great Depression Alters the Argument

Not surprisingly, the Great Depression changed the balance of argument about pensions and social insurance as well as the perspective of the participants in the debate

(Quadagno, 1988; Weaver, 1982; Haber and Gratton, 1994). As we have noted, during World War I the idea of social insurance had been tainted by an association with European, particularly German, origins. The idea of government provision of cash support was feared by many as expensive, foreign and socialistic. Social insurance was disliked and rejected by many for a variety of other reasons as well. Whether social insurance would be used to address poverty or sickness, it was avoided in the United States throughout the early years of the twentieth century. Workman's compensation, set in place early in the century, was the only public insurance program to prosper prior to the Great Depression. It had been very heavily supported by both business and labor and seemed to ride the crest of the last big wave of the Progressive Era.

However, with untold numbers of men out of work and ever increasing numbers of men, women and children being cast into poverty each month of the Depression, the old solutions of indoor relief and county by county, or even state by state, remedies for poverty and destitution were inadequate. Older people were particularly hard hit by these events (Haber and Gratton, 1994; Weaver, 1982). Especially troubling was the effect of the Depression on the ability and willingness of employers to meet their pension obligations to workers. Almost ten percent of pension

programs operating in 1929 were discontinued, suspended or defaulted by 1932. Although the defaulters were often smaller companies, even large firms that kept pension programs in place reduced the size of the benefit. Some industrialists understood that social costs had to be more widely spread or perhaps even shared nationally (Quadagno, 1988).

For decades prior to the Depression, there had been an ongoing debate about the desirability of voluntary, work related, contributory pensions, (as in private industry) versus public, compulsory social insurance. After 1929, these debates intensified and changed. The populist Senator from Louisiana, Huey Long, and the forceful pension advocate from California, Dr. Francis Townsend, moved to the center of this controversy and gave it a much more public and populist tilt (Weaver, 1982; Quadagno, 1988).

Long and Townsend

Senator Long's "Share Our Wealth Society" recommended programs to tax the very wealthy at high rates and to share that income with others. The 1934 version would have used revenue from federal income, inheritance and property taxes to grant a pension to every person over 60 years of age who had an income below \$1,000. Townsend's plan had no means test and would have distributed a pension of \$200 per month (about the same as Long's \$185 per month) to all persons over age 60. Long's efforts were quashed in the Senate, but

the Townsend Movement, as it was called, attracted many people and may have helped to reduce negative feelings about social insurance. In the opinion of Ruth Fuller, a graduate student in social work in the late 1930s, "Dr. Townsend did one striking thing, he aroused the pride of the aged," (Fuller, 1940, p.7). She explained that the aged were suffering from poverty even before the Depression, felt abandoned in industrial society, had a political inclination; and found in Townsend and his plan a point to rally behind (Fuller, 1940).

The Townsend Movement had such a powerful impact that congressmen, who had to seek reelection every other year, were actually in fear of its proponents (Numbers, 1978; Quadagno, 1988; Starr, 1982; Weaver, 1982). But the federal administration and President Franklin Roosevelt were not driven by such fears. They probably benefitted from the Townsend Movement's acceptance and the support of broad governmental intervention in personal income matters which it engendered (Weaver, 1982; Quadagno, 1988).

The social insurance measures before Congress in 1934 dealt with unemployment compensation and old age assistance. President Roosevelt made no move to support the Congressional efforts. Instead, on 8 June 1934, he made a speech that advocated an extensive social security program to provide benefits to older people, the unemployed, and

children, and proposed a committee to look into the matter (Quadagno, 1988; Weaver, 1982; Witte, 1963). Gerard Swope, of the General Electric Company and later a member of the Advisory Council of the Committee on Economic Security, was a major influence on President Roosevelt's thinking.

Social insurance for specific needs, rather than income redistribution, became the goal of the administration's social security effort (Quadagno, 1988; Witte, 1963; Weaver, 1982). Swope and other forward looking business leaders, as well as many labor organizations, favored an extensive social security system. Both the American Federation of Labor and the national Chamber of Commerce supported social security (Achenbaum, 1986; Quadagno, 1988; Weaver, 1982; Witte, 1963), typifying the broad appeal it had at its inception. There was also substantial opposition (Achenbaum, 1986; Quadagno, 1988; Weaver, 1982; Witte, 1963).

The Committee on Economic Security

In part to tap support and dull the opposition, President Roosevelt established the Committee on Economic Security (CES) about three weeks after his seminal 8 June speech. The composition of the Committee and its subordinate organizations, such as the Advisory Council and Technical Board, was not designed just to meet the President's charge to explore a broad plan of economic

security for the nation. The Committee and its members were used also to draw together support for the tough political battles that were expected. Many articles and books (some cited here) provide extensive information on and interpretation of the work and influence of the CES. The focus here will be on the actions and influence of the Committee with regard to health care issues.

The CES publication, Social Security in America provides information on the composition of the Committee. The CES, included Cabinet Secretaries plus Harry L. Hopkins, Federal Emergency Relief Administrator and an intimate of the President, which helped to give Roosevelt maximum control over the committee and its products. The Advisory Council included business, labor, religious, and civic leaders with national reputations and, usually, national constituencies (CES, 1937). The Advisory Council may have been used as an arena in which to thrash out regional and social conflicts during the process of developing a product capable of enlisting broad acceptance (Quadagno, 1988; Weaver, 1982; Witte, 1963).

The Technical Board had more than 20 members, most of whom were prominent government officials. The Technical Board did much of the work. The Actuarial Consultants numbered only four but were from the east and west coasts and the upper middle west.

Advisory groups concerned with health care included the Medical Advisory Committee, the Public Health Advisory Committee, the Hospital Advisory Board, the Dental Advisory Board, Committee on Child Welfare, and Nursing Advisory Committee. Each group was composed of people from well known institutions who also represented significant geographic and religious diversity. With the exception of the Nursing Advisory Committee and the Dental Advisory Board, physicians were very heavily represented on the various advisory groups. All together, these health care advisory groups included about 70 members (CES, 1937).

By comparison, the Advisory Committee on Public Employment and Public Assistance had only 12 members and was the only subordinate organization concerned with retirement, unemployment, employment, disability, general, and old age assistance (CES, 1937). One possible conclusion about the disparity in committee sizes is that more attention had to be paid to the health sector because of a perception of its greater complexity.

Social Security

On 17 January 1935, the President, in a special message to Congress, presented the "Report of the Committee on Economic Security" and requested prompt legislative action. Social security bills were introduced that day in the Senate and House and simultaneous hearings took place. Speed was important to Roosevelt and the Congress complied. There was

much to be resolved. Southerners had peculiar regional problems that caused them to take stances that ran from cautious to opposed in regard to some elements of the bill. Hearings and negotiation continued and changes were made until a final bill passed the House on 19 April 1935. The Senate passed its version on 19 June. There were important differences between the two versions and the conference committee work was difficult. Nonetheless, President Roosevelt signed the Social Security Acts into law on the 14th of August 1935 (Quadagno, 1988; Weaver, 1982; Witte, 1963).

Despite the substantial presence of the advisory committees concerned with health care, there was little mention of health issues in the original Social Security Acts. In 1920, the AMA had opposed compulsory contributory insurance against illness which may have reflected that period's distaste for social insurance in general. Opposition to income support programs had relaxed by the 1930s, but even a proposed study of health insurance drew aggressive opposition in 1935. However, under Title VI of the Social Security Acts, funds were made available to support state and local public health efforts (Weaver, 1982; Witte, 1963; CES, 1937).

For the long term care industry the decision not to permit inmates of a public institution to receive assistance was significant. This language doomed the almshouse and

encouraged the growth of board and care, rest and nursing homes during the following years (Achenbaum, 1986; CES, 1937; Derthick, 1970; Dunlop, 1979; Fuller, 1940).

For this study the importance of the Social Security Acts of 1935 was that they provided the aged and infirm with funds which they could use to purchase a variety of residential and nursing services that previously had been provided by families, the almshouse, or county home, depending on wealth and resources available. Few argued to retain the detested almshouses. There is no evidence of understanding on the part of public officials that Social Security's exclusion of eligibility for inmates of almshouses implied that the care of the old and sick would be turned over to the private sector. However, the fact that the Social Security Acts had such an effect has been widely acknowledged (Achenbaum, 1986; Derthick, 1979; Dunlop, 1979; Fuller, 1940; Lidz et al, 1992; Johnson and Grant, 1985; Vladeck, 1980; Weaver, 1982).

Direct statements about the intent of these Acts with regard to public facilities are rare. A legislative study written decades later stated that "This prohibition was intended to discourage the States from using the pre-Depression poorhouse system as a means for dealing with the growing problems of aged dependency" (Background Report on Nursing Homes, U.S. House, 1975, p.1).

Though the Acts were passed in 1935, contributory taxes were not collected until 1937 and payouts for retirement did not begin until 1940. Whatever the details of implementation, the effect of excluding residents of public facilities from assistance stimulated the rapid development of private facilities for the housing and care of the old and sick. This is the point from which the development of the nursing home industry in the United States should be measured.

Old and Disabled in Boston

In her 1940 thesis, Ruth Fuller gives a clear picture of the need for old age assistance in Massachusetts. Although the industrial economy provided for workers and their families while they were employed, there was rarely enough money to save for old age. On the pre-industrial family farm, older people had been revered for experience and family leadership. They could also continue to contribute to the family and its farm in limited ways. Large farm houses had made intergenerational living easy. In an urbanized industrial society, living quarters were less spacious, older people had no work and little or no contribution to make. They were often separated from their adult children and caught in poverty, particularly during the Depression (Fuller, 1940).

A 1943 master's thesis gives a sense of what the care of the old and the poor city dwellers was like in those

days. Margaret van Wagenan's study followed 29 men and women discharged from Boston City Hospital, who were receiving Old Age Assistance. Van Wagenan illustrates the improvement in living conditions experienced by those who lived in boarding homes instead of infirmaries (many urban almshouses in Massachusetts were now called infirmaries) or poorhouses. At that time there were 777 licensed boarding homes in Massachusetts, including 102 in Boston. Almost two thirds of the boarding home residents received Old Age Assistance (van Wagenan, 1943).

Boarding home licensure differentiated between the Class A home, which had a registered or graduate nurse available, and the Class B home, which had only a practical nurse. A person drawing a license for a boarding home had to be found "suitable" to run such a facility. For example, a woman making such an application would be required to have references from a combination of physicians and clergymen attesting to her "suitability," presumably related to her nursing capabilities and her moral character.

Because one state official was responsible for inspecting all 777 boarding homes only cursory yearly visits were possible. Quality in boarding homes was characterized by the inspector as difficult to measure because of the rapidly increasing number of homes, and because of the difficulty of assessment. In describing the perspective of the state inspector, van Wagenan pointed out that the

inspector felt the proprietors had to make a profit in order to get their living. He said that this was different from public facilities where workers were paid a living wage whether the operation of the facility was profitable or not.

The state inspection system, with its single inspector, was overwhelmed. Therefore it was deemed necessary for Boston to have its own inspector. The city appointed a nurse to visit and supervise its convalescent, nursing, and boarding homes. There is no description of the differences among these three types of facilities and they may have simply selected different names for themselves. Van Wagenan's physical descriptions suggest the homes occupied buildings that once were large Victorian residences in sections of the city that had become less fashionable, or worse.

Van Wagenan found that in those places she visited 69 per cent of the patients received Old Age Assistance. She seems to have assumed that proprietors were women and that the facilities were for-profit operations, as she noted exceptions. The average age of the residents in her group was 77 years with the youngest being 68 and the oldest 90. Three quarters of the residents suffered from severe physical disabilities.

Van Wagenan described a burgeoning form of business enterprise dominated by women and nurses who first had to seek the approval of male physicians and clergymen to begin

their work. Much expansion occurred during this time despite the many negative pressures on growth, such as labor and material shortages caused by the Second World War. From these studies one might conclude that the financial engine of Old Age Assistance may have been even more powerful than other researchers have described. Such assistance led to private boarding homes becoming "...an important part of the pattern of care for the aged in Boston," according to van Wagenan (1943, p.60).

The 1939 amendments to the Social Security Acts increased the range of occupations covered, altered tax arrangements, hurried payouts for retirement, and increased benefits. For long term care, however, it was the Old Age Assistance package in the original Acts that had the most remarkable effect. It had made private facilities available to the poor and to people of moderate means.

Further Attempts to Create a National Health Plan

In 1939, the Roosevelt administration attempted again to establish a national health program. An important feature was the proposal to provide financial assistance to the states for the construction of new health facilities. The legislation also would have required states to regulate health services if they accepted federal funds (U.S. Senate, S1620, 1939). This proposed legislation stated that 40 million people were medically needy in the United States, proposed monies for each of several types of facilities, and

highlighted the need for curative hospital services to help those for whom the preventive public health strategies of the Social Security Acts were not enough.

The Massachusetts Medical Society opposed the legislation. It feared the great expense the country would face if it undertook such a program of medical care and facilities construction. Although doctors' immediate income might benefit, the Massachusetts Medical Society feared the program would drive the country further into debt. It also questioned the need for additional hospitals. The Society noted that no one in Massachusetts was more than 50 miles from a hospital, except for the residents of Provincetown at the end of Cape Cod (U.S. Senate, Lund, 1939). The national health care program was not passed.

The following year the President and his administration focused on legislation proposing the construction of health care facilities, particularly hospitals. Roosevelt expressed specific concern for the inequalities that existed among states with regard to health facilities. He wrote that "There is still a need for the Federal Government to participate in strengthening and increasing the health security of the nation." (U.S. Senate, President's message, 1940, p.3).

In the proposed Senate version, the Wagner Bill, hospitals constructed under the legislation would be owned

and operated by the federal government. Republican Senator Robert Taft's response to this was resoundingly negative.

The American Medical Association (AMA), also opposed the bill for several reasons. The AMA was most concerned about the possible development of a system of federal hospitals for the general public. Despite this concern, some effort to increase hospital bed strength was welcomed by the AMA and others, especially to provide facilities for Negroes in the South. The racial inequality in hospital bed availability was mentioned in the 1940 hearings on hospital construction. It recurred as the discussion of facilities requirements continued and the AMA presented detailed testimony on the need for health care facilities (U.S. Senate, Fishbein, Cutter 1940).

Not surprisingly, the American Hospital Association (AHA) also opposed this bill, with its specter of public hospitals competing with private hospitals. On the other hand, the National Tuberculosis Association, the American Public Health Association of New York, the National Hospital Association (representing black hospitals), the National Association for the Advancement of Colored People, and a number of other public health groups supported the legislation. The bill's proposal for publicly constructed hospitals that would have centralized standards and local operating authority was consistent with their goals.

A notable omission was any discussion of nursing home facilities. The only nursing interest to testify was the National Association of Colored Graduate Nurses, whose interest was largely racial. The racial disparities with which the Colored Graduate nurses were concerned were widely acknowledged. For instance, Dr. Morris Fishbein of the AMA said, "...the one most important problem today is the provision of adequate beds for Negroes in certain States of the South," (U.S. Senate, Fishbein, p.45, 1940).

Those in opposition to this legislation supported the idea of somehow increasing the number and quality of hospital facilities in the country. The President's message had talked about reducing the inequality of hospital availability around the country, and even opponents like the AHA agreed with this aspect of the bill.

Letters from most of the states were entered into testimony: Alabama's state health officer complained that there were only two hospitals in the whole state, while Massachusetts' health officer acknowledged that his state was adequately provided for. Like Senator Taft, most opponents objected to the fact that facilities constructed under this act would be owned by the United States government, setting a precedent for more extensive development of public hospitals (U.S. Senate, S3230, 1940). Contrary to the Weisbrod theory, public sector activity in health care was not widely welcomed by substantial numbers

of influential people in the health professions. Whether they represented the more general public cannot be determined from these hearings.

As the huge effort required by World War II began to show some signs of success, the Senate once again considered the health of the country, holding a series of hearings in 1944 on "Wartime Health and Education." Much testimony was offered by Dr. Thomas Parran, Surgeon General, United States Public Health Service, who underscored the need to construct facilities and train health care professionals. Dr. Parran noted that where there were no hospitals, there often were no doctors. He described at some length the concept of an integrated health service system of hospitals and health centers offering graduated levels of care ranging from the local health centers through what he called rural, district, and base hospitals.

Of special interest is Dr. Parran's statement that some private hospitals were proprietary rather than voluntary, but while nominally for-profit, these institutions rarely made any money. He said that these facilities, which made up about 10 percent of the non-federal beds, had been built not so much for profit, as to meet community need in places where there were no other health care facilities (U.S. Senate, Parran, 1944, p.1779). Dr. Parran's statement does not say how or why for-profit facilities could be built where not-for-profits and public facilities had not been or

could not be built. The availability of private capital may have been a key element. If Starr's and Moroney and Kurtz' description of the enhanced profitability of hospital practice to physicians is accurate (see Chapter 2, p.19, Moroney and Kurtz, 1975; Starr, 1982), then one may imagine the capital being supplied by local physicians. They may have wished to practice in a modern, private facility and were willing to take the return on their investment from their more profitable practices rather than from the hospital operation itself. In the 1944 hearings, as in 1940, the AMA and the AHA reiterated their desire to support construction of more hospitals but argued against publicly owned or operated facilities. No mention of nursing homes was made in these hearings despite the fact that they were becoming more common in urban areas. Chronic disease hospitals were mentioned, but only in reference to hospital based services (U.S. Senate, "Wartime Health and Education," 1944).

The Beginning of Hill-Burton

The administration altered its strategy in 1945. For the 79th Congress, the legislation filed in the Senate was designed to provide a survey of existing hospitals and health centers in order to support planning for new facilities and to distribute hospital construction grants to the states. Once again, no nursing home owners or organizations offered testimony. This time the proposed

legislation would permit the states to assist private organizations in the construction of voluntary (not-for-profit) facilities and the AHA and AMA supported it. Senator Robert Taft again was concerned with the centrist language of the bill, but acknowledged its substantial change from earlier legislative efforts (U.S. Senate, S191, 1945). Hearings continued into the Congress' second session and involved members of a variety of public health, hospital, farm, rural health, social welfare organizations and other advocates who testified in its support. The legislation had matured from its origin as the National Health Program proposal of 1939 (U.S. House, S191, 1946). Once again, neither the nursing profession nor the nursing home industry had any representatives of record at the hearings.

In 1946 the Congress passed, and the President signed, the Hospital Survey and Construction Act, widely known as Hill-Burton, after its legislative sponsors. It was designed to inventory existing hospitals and assist with the construction of additional facilities as needed. The program was revised and expanded over time so that it eventually included long term care facilities and offered loan guarantees as well as grants for financial assistance to such health facilities. In 1954, for example, it was expanded to include grants to public and nonprofit nursing homes. In 1959, a mortgage guarantee program for

proprietary nursing homes was established by Congress under the auspices of the Federal Housing Authority (Dunlop, 1979; Lave & Lave, 1974; Public Health Service, 1958).

Hill-Burton Benefits for Nursing Homes

In 1949, about two and a half years after the initial implementation of Hill-Burton, hearings were held on proposed Hospital Survey and Reconstruction Act (Hill-Burton) amendments. The amendments were to increase the funds available through Hill-Burton, to extend its authority beyond hospitals and health centers on an experimental basis, and to let the states determine project funding levels so that federal participation might be substantially increased from the earlier one-third of costs. It also extended Hill-Burton to 1955, four years beyond the original 1951 expiration date. On this occasion, the American Association of Nursing Homes (AANH) and other nursing home organizations testified against the inclusion of nursing homes in the Hill-Burton program, largely because the inclusion would extend only to nonprofit facilities, and not to the for-profit organizations that made up most of the industry (U.S. Senate, Hill-Burton, 1949).

Social Security Acts of 1950

By 1950, the pressure for increased benefit payments to individuals by the Social Security system was substantial and resulted in a set of amendments which liberalized Social Security in many ways. A change that effected nursing homes

was allowing payments to be made directly to nursing homes on behalf of individual residents. In addition, payments to residents of public facilities was also authorized. The language in the amendments referred to "health care providers" and reflected the increasing medicalization of all institutional care (Achenbaum, 1986; Dunlop, 1979; Lidz, et al, 1994; Nash et al, 1988; Vladeck, 1980). While the inclusion of public facilities under these 1950 amendments changed a fundamental requirement of the 1935 Acts, in which residents of public facilities were excluded from benefits, in matters of long term care it hardly mattered. The dominance of private facilities, and especially of for-profit nursing homes, had been established beyond any question by 1950. Although this fact is to some extent denied by Vladeck (1980) and others, the numerical dominance of private providers was well established by 1950.

Nonprofit Homes Are Covered by Hill-Burton

With Hill-Burton in place for hospitals, there was pressure to include nonprofit nursing homes in the program. In the spring of 1954, the Subcommittee on Health, of the Committee of Labor and Public Welfare took up the portion of the "President's Health Recommendations and Related Measures." President Dwight Eisenhower's proposals included reauthorization and changes to the Hospital Survey and Construction provisions of the Public Health Service Acts (Hill-Burton). While the 1949 administration proposal had

discussed surveying nursing homes and making pilot grants for their construction, opposition from the proprietary industry had been fierce, and was successful. Yet everyone felt a need for more nursing homes. In the 1954 administration proposal, grants to states for construction of not-for-profit nursing homes was presented as a full-fledged extension of the Hill-Burton program.

Since President Eisenhower and the Republican party had a reputation for being somewhat conservative in the expenditure of public funds for private purposes, the administration's stance on this issue was unexpected. In fact, the Republican plan that was presented by Oveta Culp Hobby, Secretary of Health, Education and Welfare, and her staff was remarkable for its centrally planned, fully integrated, and systematic approach. It seemed a logical continuation of the thinking presented by Dr. Parran, Roosevelt's Surgeon General, in 1944 (U.S. Senate, Parran, 1944), and again in 1945 (U.S. Senate, S.191, 1945). A centrist view of health care organization and monitoring was not surprising in the context of the Rooseveltian scheme of a greater society. However, the continuation of this philosophy, with its implicit regulatory framework ran counter to the image of a Republican party focused on a smaller federal government and greater state and local autonomy.

The Profits Fight the Nonprofits

Letters entered into the hearing record from more than a dozen states maintained that public support of nonprofit nursing homes would provide unfair competition for the proprietary owners. The AANH pointed out that for-profit owners made up the bulk of the industry, had invested funds and effort to serve the disabled elderly, and deserved the right to be free of unfair competition from publicly supported, voluntary (nonprofit) competitors. Robert Muse of AANH argued against federal support of voluntary facilities unless comparable assistance was available to proprietary facilities. Such assistance might include long term loan guarantees (U.S. Senate, President's Health Recommendations, 1954).

In Muse's testimony and in the letters are expressed a clear sense of entitlement. Nursing homes had grown from a few, nurse run boarding homes in the late 1920s to an increasingly powerful and important for-profit health industry with national organization and influence. Mrs. Lela Horton of the Texas Nursing Home Operators Association concluded her letter by saying, "I am 100 percent opposed to socializing the nursing home in any way, and socializing is what it is when the operator has to look to the Government for money on which to operate." The Ohio Association of Nursing Homes, in opposing financial support for nonprofits said, "It is an encouragement for the rebirth of the poor

farm." The Mississippi State Association of Nursing Homes said, "It would be wise to visit the patients in proprietary nursing homes and those in state institutions and get first hand information on how people feel about their surroundings." The Minnesota Association of Nursing Homes asked for government guaranteed loans for proprietary homes so that they could more easily continue to meet the demand for facilities. The Licensed Nursing Home Association of New Jersey makes a point in keeping with the three sector theory of Weisbrod. Referring to research done by the committee and administration, it said, "Your survey also indicates that it is less costly to build and operate public or nonprofit nursing homes than hospitals, but it should also state that private enterprise can build and operate for less than either." (U.S. Senate, President's Healthcare Recommendations, 1954 p. 200-204.) Letters from 15 state nursing home associations were entered into testimony.

In presenting the Eisenhower administration's proposed amendments, Secretary Hobby and Surgeon General Leonard A. Scheele argued that the Hill-Burton program had been widely accepted and successful in expanding the country's clinical facility capacity. Dr. Scheele contended that nursing homes were obviously more appropriate for the chronically ill and were much more cost efficient than acute hospitals.

An interesting aspect of the testimony is that Scheele and the government clearly did not have accurate data on

what nursing homes and nursing home services cost. In his presentation Scheele said that nursing homes cost from \$2.00 to \$8.00 per patient day depending upon place and type of facility. In the hearings specific national average costs were used for acute care hospitals (\$18.35 per day) and chronic disease hospitals (\$6.63 per day), but there was no national average for nursing homes, suggesting that one did not exist (U.S. House, Hobby, Scheele, 1954, p.15).

The administration explanation for focusing on not-for-profit facilities was a very simple one. That was how hospitals were done, that was the way the program was designed, and that was the way nursing homes would be done. The beauty of this explanation is that it avoids any discussion about the nursing home industry being different from the hospital industry, about the supposed undesirable nature of profit in health care, and about providing an advantage to one competitor over another. At the same time, it acknowledged the perceived need for additional long term care and nursing home capacity. Said Scheele, "We are well aware that there are over 9,000 proprietary nursing homes now in existence. Nor can there be any doubt as to the need for additional high quality nursing homes of this type" (U.S. House, Scheele, 1954, p.19).

Through their questions, Representatives Beamer, of Indiana, Harris, of Arkansas, and Springer, of Illinois, were particularly assertive about the desirability of

supporting the good work of proprietary nursing homes and about moving the whole program forward. Their questions and positive statements about the for-profit side of the industry may have reflected their political orientation. However, it also may be read as an indication of the careful and successful lobbying efforts by the ANHA and its state affiliates (House, Public Health Service Act, 1954).

The relative ignorance of people outside the nursing home industry about its scale and operations was reflected in the testimony of industry figures. Robert Muse objected to the idea of federally sponsored nursing homes competing with proprietary facilities already in existence. He numbered existing facilities at 20,000, a considerably larger number than the 9,000 figure used by the Eisenhower administration. He argued for long term loan guarantees for the proprietary industry, to balance the grants available to not-for-profits under the proposed legislation. The question of construction costs, financing problems, and other operating aspects of the nursing home industry also were brought up by Muse and others (U.S. House, Muse, Edwards and Mustin, 1954).

In one exchange, Representative Rogers was particularly outspoken about the apparent desirability of private facilities. "Mr. Muse, I do want to commend you and your organization for wanting to promote private enterprise and get away from government domination and ownership." (U.S.

House, Muse, Rogers, 1954, p.114). At a continuation of the same hearings later in 1954, a negative view of publicly owned facilities was expressed again by an industry figure, Zuzie Siegal, President of the National Association of Registered Nursing Homes. She said, "Have all of us forgotten the horrors of the old almshouse? Even the very earliest of proprietary nursing homes represented an unquestioned improvement over the poorhouse." (U.S. House, Siegal, 1954, p.131).

Although, the hearings at which Miss Siegal spoke were an extension of those held earlier, they dealt with a different topic. The May hearings had considered loan guarantees to for-profit providers. The tone of the industry comment then was that loan guarantees for proprietary facilities was a good idea, but such guarantees should not be available to not-for-profits. Their argument was that, by being included in Hill-Burton plus freedom from some taxation, the not-for-profits had enough of a competitive edge already (U.S. House, Siegal et al, 1954).

Other Events of the Late 1950s

Other important changes during this era included:

The 1956 amendments to the Social Security Acts eliminated per capita monthly ceilings on federal matching cash assistance payments.

The establishment of a loan program for proprietary nursing homes was accomplished under the aegis of the Small Business Administration.

The creation of a mortgage insurance program under the Federal Housing Authority, a spin off from the Hill-Burton program that took effect in 1959.

The passage of the Kerr-Mills Act of 1960 that was the predecessor to Medicare, Medicaid, and the Older Americans Acts of 1965 (Dunlop, 1979).

At the hearings that preceded the passage of the 1958 Housing Act, which included the establishment of the FHA loan guarantees for nursing homes, 1957 survey data on the number and types of nursing homes in the nation was presented. The data showed there were 15,530 proprietary nursing homes with 263,471 beds, 1,429 voluntary nursing homes with 78,986 beds, and 496 public facilities with 49,846 beds. Obviously, the dominance of the proprietary sector of the industry had matured and strengthened as it had yet more beds and more facilities than the nonprofits and public facilities combined (U.S. Senate, Mustin, 1958).

The argument for mortgage loan guarantees was that the country needed additional nursing home capacity, proprietary nursing homes had demonstrated an ability to build and operate such homes, and it was increasingly difficult to obtain mortgage funds at reasonable rates for single purpose structures like nursing homes. Therefore, the federal

government should help by offering long term loan guarantees for such facilities. Other, shorter term loan opportunities such as those of the Small Business Administration, were unsuitable for this purpose because the terms were too brief (U.S. Senate, Mustin, 1958). Four years after the voluntary nursing homes were given access to Hill-Burton grants, proprietary nursing homes achieved access to FHA loan guarantees. Today, these loan guarantees remain a central financing tool for nursing homes.

Hill-Burton became available to nonprofits in 1954. However, the Hill-Burton program was never heavily used by nonprofit nursing homes. There were several qualities to Hill-Burton that limited its utility. Although it was a grant program, for long term care Hill-Burton covered only 33 percent to 60 percent of the costs of a nursing home project. There was also an application process, that consumed time and energy.

For Hill-Burton you had to get on a schedule, submit a development application, have it considered by the lead the state agency that set priorities for that state with regard to need, and be reviewed on a competitive basis with projects similar to it. If a proprietary organization came in and met that need, then by the time that project got funded and built, it might not be needed (Dortch, personal communication September, 1997)

As Chief of Policy and Research, Office of Special Programs for the Health Resources and Service Administration, Dr. Eulas Dortch is expert on the Hill-Burton program. He points out that funds were allocated by Congressional language and a very small proportion of Hill-Burton funds was ever directed toward nursing homes. Funds for Hill-Burton became reduced in the early 1970s and ended in the middle of that decade (Dortch, personal communication, September 1997).

In contrast to Hill-Burton, the Federal Housing Administration (FHA) Section 232 Mortgage Insurance Program remains robust to this day. Working with a bank or mortgage company, a proprietary or nonprofit organization can apply to the FHA to guarantee up to 90 percent (95 percent for nonprofits) of the total cost of a loan to build a new or rehabilitate an existing facility. These loan guarantees provide favorable interest rates, may include both construction and permanent financing, and in the event of default, the guarantee is paid to the lender without recourse to other assets of the original borrowers. These loan guarantees are extensively used throughout the nursing home industry (Heartland Capital, 1997). In fact, while Hill-Burton was very important for hospital construction in the United States, it never became an important source of capital funding for nursing homes. In the face of cost based reimbursement, the most apparent strength of Hill-

Burton, the fact that it was a grant and did not need to be repaid, was unimportant. Medicaid and Medicare, as well as other public and private payers for nursing home services were quite prepared to include the amortization of capital costs within their payment arrangements.

Public Policy Has Established For-Profit Dominance

Between 1930 and 1958, the nursing home industry, and particularly the for-profit portion of it, expanded very rapidly in size and in sophistication. Much of this expansion was the result of federal government programs. One series of actions was designed to improve the economic situation of the older citizen. Another set of actions was designed to increase the efficacy of health care by expanding its availability and coordination, especially through facilities development. These policies were introduced under the liberal, Democratic Roosevelt administration with its obvious bent toward big government and central control. Surprisingly it continued right through the Republican Eisenhower administration with a focus on federal support and control that was little changed from some of the Roosevelt ideas. As a result of these policies, the nursing home industry emerged as a powerful force by the mid-fifties. In 30 years for-profit nursing homes had begun to move from boarding homes owned and run by individual nurses to larger facilities increasingly owned and operated by businessmen who successfully banded together

in state and national organizations in order to influence policy and learn from one another. Congressional testimony, masters' theses from that time, other scholarly works, as well as the Appendix to this study all confirm that massive changes occurred in the nursing home industry during these years, largely as the result of public policies.

CHAPTER 4

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CHAPTER 5

THE COMING OF KERR-MILLS, MEDICAID AND MEDICARE

Earlier chapters have reviewed the development of services for the old and sick from the Colonial era through the beginning of the twentieth century, examined the economic and social programs that developed in the nineteenth century, and surveyed important activities in residential and health care immediately preceding passage of the Social Security Acts in 1935. Chapter 4 also provided information on service modalities and financing support for nursing homes that were developed in the 1940s and 1950s. This chapter takes us into the early days of the Medicaid and Medicare era, beginning with the Kerr-Mills Act and its Medical Assistance for the Aged program.

Much of the information presented in this chapter comes from Congressional records. The McNamara hearings used Congressional hearings as an advocacy tool. Hearings held all over the United States were used as an important public policy tool to focus the attention of the Congress and the country on the needs of the elderly. These hearings contributed to the passage of Medicare by bringing the arguments to the public. They helped examine nursing home issues and provided an extensive public record that includes the views of diverse interested parties.

The Medicaid era has seen the number of nursing homes proliferate as never before. The ownership of nursing homes

by large corporations had begun earlier, but with the arrival of substantial federal funding, the chain ownership trend became robust. As in the 1950s, the huge increase in the number of nursing homes and related bed strength was led by private and for-profit ownership.

This era of nursing home growth can be dated from 1960 when the Kerr-Mills legislation, which would provide health care to the poor, was signed by President Dwight Eisenhower. It is ironic that President Eisenhower signed this keystone legislation into law and that it was named after Senator Robert Kerr of Oklahoma and Representative Wilbur Mills of Arkansas. The president was against compulsory health insurance and directed his administration to oppose it. Senator Kerr also had intended to oppose any medicare style plan that made it to the Senate, and Wilbur Mills, as Chair of the House Ways and Means Committee, had repeatedly blocked legislation like medicare for fear of its costs (until the passage of Medicare in 1965 the generic term was not capitalized in Congressional documents) (David, 1985; Marmor, 1973; Poen, 1979).

Conservative support for this bill arose from concerns that a much broader bill might be passed instead. Historically, there had been no real hope for a social health insurance program since President Truman and his advisors had tried to break the opposition to "socialized medicine" by focusing on federally financed health insurance

for the elderly. They failed, and only pro-forma efforts had been made during the Eisenhower years. During the Eisenhower administration, however, the Hill-Burton law, which supported facility construction in exchange for free care for the poor, was expanded and Small Business Administration loan guarantees for health providers were increased. Eisenhower preferred to support private sector efforts that provided health care to the poor, such as Hill-Burton and the SBA program, as an alternative to more aggressive direct federal involvement, such as medicare (David, 1985; Marmor, 1973; Poen, 1979). The President and the Congressional conservatives supported the Kerr-Mills proposal in order to undermine a renewed effort to pass a medicare bill.

Despite its conservative origins, Kerr-Mills was the first federal law that specifically provided payment for a broad range of health care services for the old and poor. The program would reimburse a portion of whatever health care expenses a state undertook for poor elders. Payment was made on a sliding scale that ranged from approximately 50 to 80 percent of the state's cost, based on a formula related to the number of services covered, much like Medicaid today. Kerr-Mills was entirely voluntary, so states could elect to cover no services, few services, or a broad range of services. Most states elected to cover few services, which reduced the law's effectiveness. However,

Kerr-Mills authorized the first broad spectrum, federal coverage of health services for the poor, even though its application varied widely from state to state (Achenbaum, 1986; David, 1985).

The McNamara Hearings

By the late 1950s, the traditional congressional opposition that had blocked political interest in federal health insurance was weakening. The Kerr-Mills proposal was a response to bills filed by Democratic Senator John Kennedy of Massachusetts and Democratic Representative Aime Forand of Rhode Island. The Forand bill had originally been filed in 1958, was resubmitted in succeeding Congressional sessions, had had good support, and now required some Congressional response. Senator Pat McNamara's Senate Subcommittee on Problems of the Aged and Aging conducted hearings around the country that were very well attended by older citizens. Time and again, older voters expressed deep concern about health care costs they faced (Marmor, 1973).

During this era the Congress was becoming significantly more liberal and was changing in a variety of ways. For instance, in 1958 the Democratic party gained 12 Senate seats. They were all Northern Democrats and were generally more liberal than Southern Democrats and the Northern Democrats who had preceded them. Between 1959 and 1965, 23 more Northern Democrats were elected to the Senate. For an institution with only 100 members, this resulted in

substantial ideological change. The new members with their new agendas, made many changes in a once traditional body (Sinclair, 1989).

The thousands of pages of testimony from Congressional hearings of the mid-1940s through the early 1980s make it clear that the hearings themselves changed. In the late 1940s and early 1950s, such hearings were dominated by government officials and leaders of interest groups who were based in Washington or traveled there frequently. By the time of the McNamara hearings in 1959 and 1960 the public in general was invited and members of the public, local officials and journalists gave testimony as well. The new type of hearings not only informed the Congress, but were also important public and publicity events that took place across the country. These hearings appear to have been designed to shape policy by influencing voters as well as public officials.

The McNamara hearings drew testimony from friends of the nursing home industry and other interested groups. At the "Aging and The Aged Hearings" in Boston, a community group from nearby Norwood expressed concern that no sufficiently powerful local authority existed to ensure that the five nursing homes in their town provided quality care. The group particularly objected to overcrowding in these homes and requested legislation to prevent "a room in a former private residence, used by one or two people, being

occupied by seven or eight patients when converted to a nursing home." (U.S. Senate, Women's Community Committee, p.440, 1959). They clearly felt that such abuses existed. They also recommended that only a nurse or physician be permitted a license to operate a nursing home.

The Director of Public Health from Brookline, Massachusetts, Dr. Leon Taubenhau, was also concerned about the quality of contemporary nursing homes. "Nursing homes are a major industry in Brookline," he pointed out, with about 600 nursing home beds that would soon grow to be some 700. These beds were monitored by the state for medical issues and by the town for safety and sanitation concerns. Like the group from Norwood, Tabenhaus feared that this arrangement led to oversight shortcomings. He was concerned that smaller nursing homes were not improving their quality because of the small sum they received for the care of publicly aided patients. Noting that "Most of the inhabitants of nursing homes are on public welfare," he advocated higher payments to these facilities (U.S. Senate, Tabenhaus, 1959, p.368). Tabenhaus expressed concern that many members of the public could not understand why public dollars were used to support privately owned nursing homes. The resulting reluctance to pay fairly for services led to some of the suffering experienced by publicly supported residents in these facilities.

Massachusetts State Representative Irene K. Thresher presented some of the findings of a legislative committee charged to look into problems in Massachusetts nursing homes. Thresher reported that the committee found that, since 1945, more and more people depended on more and more nursing homes, and a great many of them were on public assistance.

The legislative committee report described two major problems. The first was economic; state and federal financing mechanisms were expected to be increasingly stressed as the numbers of publicly assisted residents increased. The second problem was the humanitarian concern that the standards of care for nursing home patients were low.

The proposed solutions seem as familiar today as do the problems. To address the economic issues the Thresher committee report called for improved cost accounting by nursing homes, cost based rates, state inspection of the facilities to ensure that funds were being used properly, review of owner suitability, and review of the medical care provided to make sure that it was clinically adequate and financially appropriate.

Humanitarian problems addressed by the report included concern for the physical environment (particularly crowding and safety issues), and the need for recreation programs, proper medical care, good nursing services and sound

administration to assure that all the other necessary elements would be in place. Solving the economic problems would help resolve the humanitarian concerns (U.S. Senate, Thresher, 1959).

Light was also shed on the use of Hill-Burton by nonprofit nursing homes. The Report of the Committee on Public Welfare Relative to Persons on Public Assistance in Nursing Homes was published in January, 1958, by the Massachusetts Legislature. It calls for reforms that were made by the Commonwealth, which were referred to in Thresher's Congressional testimony. For this study it is interesting to note that the Massachusetts Committee did not investigate any "charitable" nursing homes, but said instead, that people using them were generally satisfied. In addition, one of its findings was that

Very few institutions in our State have taken advantage of funds for nursing care construction as outlined in the Hill-Burton regulations. We are at a loss to understand this and feel that further investigation into the possibility of obtaining such funds is necessary.
(Massachusetts House of Representatives, 1958, p.13).

The Committee also recommended that state tuberculosis sanatoria be converted into state run nursing homes as dictated by an earlier act of the Legislature (Massachusetts State Legislature, 1959). It appears again that public sector ownership and operation of nursing homes had met significant resistance.

The testimony of the nursing home trade organization at the Boston hearings was similar to that of citizens and officials. The Executive Director of the Massachusetts Federation of Nursing Homes, Edward Connelly, reported that most residents of nursing homes were over age 65 and many were on public assistance. He said that nursing homes were often caught between the demand for high quality services and low payments from public coffers. He went on, remarkably, to complain about chain ownership of nursing homes. He implied that chain owners were primarily interested in the commercial aspects of the industry and he pointed out that, when one individual owns many homes, a sort of "absentee ownership" is inevitable. His testimony highlighted the rapid and continued growth of nursing homes in Massachusetts despite the scarcity of public assistance funds to pay for this growth (U.S. Senate, Connelly, 1959).

Later in October, 1959, when the McNamara hearings moved to San Francisco, the President of the California Association of Nursing Homes, Clarence Reding, called for federal classification and grading of nursing homes, arguing that the federal financial contribution justified such a step. In his testimony can be found the tacit admission that many facilities were below standard. "Like many of the other states," he said, "we have many facilities which have been in existence for many years and are considered inadequate" (U.S. Senate, Reding, 1959, p.854-855). He

recommended that the upgrading of facilities be encouraged, and that they should be classified according to their physical plants and care capacities. However, Reding objected to publicly funded, non-tax paying nursing homes taking private pay patients. He reasoned that, by accepting these commercially attractive customers, the nonprofit and public facilities were putting tax paying homes, in which individuals had invested considerable capital and effort, at an unfair disadvantage (U.S. Senate, Reding, 1959). He also objected to the government supporting nonprofits in their renovations and expansion. "We see no reason, as taxpayers, why government should channel our tax money directly to our competitors (the so-called nonprofits)..." through the Hill-Burton program (U.S. Senate, Reding, 1959 p.857).

At MacNamara hearings in Dade County, Florida, the views of the Committee on Nursing Homes, Dade County Workshop Conference on Aging, were presented by Mr. Arthur Kalish. This report stressed the need to provide sufficient funds to support the level and quality of services which older citizens deserve. "Care cannot be provided without money," Kalish said (U.S. Senate, Kalish, 1959, p.1597). Concerned about supporting the indigent in nursing homes, the Florida committee recommended a standardized accounting system, cost based reimbursement, liens on the houses of those receiving public support, an increase in Old Age Survivors Insurance (OASI) and Old Age Assistance (OAA)

payments, and advocacy for permanently available health insurance for elders (U.S. Senate, Kalish, 1959).

While the MacNamera hearings covered a variety of topics, health care costs and nursing home issues emerged time and again, all over the country. The need for higher standards, for more beds, for higher levels of payment, as well as the rapid growth of the industry and its for-profit nature were discussed repeatedly.

In these hearings there also was extensive testimony about the need for more affordable hospital care for the elderly and the dire economic impact of health care costs for those who had limited incomes. Support for the Forand bill was volunteered by many individuals and organizations throughout the nation. All proposals for medical assistance for the elderly were referred to generically as "medicare bills".

The forces favoring some appropriate change had become so strong that Eisenhower had trouble keeping his own administrative officials in line. By the time Eisenhower had been out of office for a few weeks, his vice president and several of his former cabinet members had already voiced support for some social health insurance program, particularly for the aged (David, 1985; Marmor, 1973). It was only the fierce opposition of groups like the AMA, the fear in some government circles of enormous expense, and the now familiar fear of social insurance as socialized,

communistic and foreign that slowed movement toward its creation (Achenbaum, 1986; David, 1985; Marmor, 1973).

Special Committee on Aging Hearings

After the McNamara hearings, the Senate formed the Special Committee on Aging which, in turn, formed a Subcommittee on Nursing Homes that conducted nationwide hearings in 1961. These hearings were the outgrowth of the continuing concern for the economic and social well being of aging citizens. As the hearings reveal, issues of personal safety related to fires in nursing homes were especially dramatic.

Senator Wayne Morse of Oregon chaired the Subcommittee on Nursing Homes and conducted the first hearings in Portland, Oregon. He posed a series of questions: Are there enough nursing homes? Are they the right kind and right quality? Can people afford them? Is there something else that should be done (U.S. Senate, Morse, 1961)?

One Oregon physician was particularly concerned about the profit making nature of nursing homes. He pointed out that 40 years earlier privately owned, proprietary hospitals had often committed the sort of abuses that the profit motive might encourage. "Now that practically all hospitals are operated on a non-profit basis, most of the defects no longer exist," Dr. Morton H. Goodman observed (U.S. Senate, Goodman, 1961, p.51). He felt that a shift away from the for-profit structure was nearly inevitable in the nursing

home industry, at least when public assistance was involved, and that, as with hospitals, this change would resolve most abuses.

Fire is probably the most feared catastrophe in residential facilities for the disabled. At the hearings in Washington State, Edmund Jacobs, head of that state's nursing home trade organization, testified that the introduction of a licensing requirement for nursing homes there was triggered by "a disastrous fire in a nursing home in Hoquiam, Washington, in which 18 patients burned to death..." (U.S. Senate, Jacobs, 1961 p.158).

Jacobs also noted that both the industry and its use of nurses had grown rapidly since 1951. "In 1951 there were 80 registered nurses employed in nursing homes..." he said. "In June 1961, there were 768 RNs and 608 LPNs employed in licensed nursing homes in this state" (U.S. Senate, Jacobs, 1961, p. 159). A greater number of people in his state were in nursing homes and more were on public assistance of some kind than had been in the past. Public assistance was needed by these people because private funds available through Social Security could not meet the cost of nursing home care, and because more disabled people found nursing homes a good choice as quality improved. Even though nursing homes were expensive, overall costs could be reduced by getting people out of hospitals and into nursing homes, because hospitals were even more expensive. Jacobs also

pointed out that nursing homes were a big business, caring for many, employing many, and purchasing many goods and services from others (U.S. Senate, Jacobs, 1961).

When the subcommittee hearings moved to Hartford, Connecticut, the Commissioner of Health for Connecticut, Dr. Franklin Foote, reported that in 1945 his state had planned to build five publicly operated infirmaries, but had not done so because the number and variety of privately owned nursing homes in Connecticut made such large, public facilities unnecessary. "Fortunately, these institutions were never built. ...I am sure the issue is closed," he said (U.S. Senate, Foote, 1961, p.405). Foote reported that, even in 1961, the only requirement to receive a license to operate a nursing home in Connecticut was a note from a local physician and other important community figures (U.S. Senate, Foote, 1961).

Bernard Shapiro, Connecticut Commissioner of Public Welfare, told the subcommittee that half of his state's welfare expense was for medical costs, that 66 percent of its nursing home beds were paid for by welfare, and that Kerr-Mills would be a big help in meeting these costs. Although Kerr-Mills was signed into law in 1960, April 1962 was the first month that it would be available in Connecticut (U.S. Senate, Shapiro, 1961). Such delays were occurring in other states as well. After the legislation

was passed, issuing the rules and getting states to comply with basic requirements could take months and years.

Senator Benjamin Smith of Massachusetts presided over the Subcommittee on Nursing Home hearings when they came to Boston. Dr. Leon Tabenhaus of Brookline once again testified, repeating much of the statement he had made in 1959 before the Subcommittee on the Problems of the Aged and Aging. On this occasion, he added a widely understood but rarely spoken fact about nursing homes: that they are something of a pariah in the health care community.

In our desire to help nursing homes raise standards, we are often inhibited by the philosophy that nursing homes are proprietary institutions and therefore should not receive any public support. We forget that most of the patients in nursing homes are financed by tax dollars and that a few extra tax dollars might be a good public investment if better patient care is assured.

Proprietary nursing homes, unlike almost any other type of medical care institution, are isolated from community health resources. This is due to their historical development. Because they originated as commercial enterprises set up by nonmedical entrepreneurs, they were ignored and looked down on by the medical profession and hospitals. As a result of this original rejection they are still insulated from the hospital and the medical profession. They are often regarded by those who could help the most as a necessary evil. (U.S. Senate, Tabenhaus, 1961, p.491)

Tabenhaus said that stricter regulation alone was not the solution to nursing home problems. He argued for reducing the isolation of the nursing home industry from the

rest of the health care system and he clearly saw a role for local, state and national governments in accomplishing this.

During the same hearings some light was cast on the question of why voluntary organizations had not become more deeply involved in the rapid, decade-long expansion of nursing homes. Dr. A. Daniel Rubenstein, Deputy Commissioner of the Massachusetts Department of Public Health, testified that rates of reimbursement for publicly assisted patients in nursing homes were set by the department's Division of Hospital Costs and increased quality would require increased funding.

He noted that more voluntary organizations had not taken advantage of the Hill-Burton program for the construction of nursing facilities because they lacked the "accumulated reserves" necessary to support the operation of new and larger facilities.

At the currently established rate of reimbursement for public assistance patients, it would not be practical to accept patients on public assistance for nursing home care and such groups would have to limit their activities to private patients, thereby defeating one of the primary purposes of this legislation; namely, to provide care for all patients including those on public assistance. This means, therefore, that the usual proprietary nursing home must care for the greatest bulk of nursing home patients, and for this we are extremely grateful to them (U.S. Senate, Rubenstein, 1961, p.501).

Echoing Rubenstein's view, Edward Connelly of the Massachusetts Federation of Nursing Homes testified that,

since it was fiscally impractical for voluntary and government nursing homes to meet the growing need for services, it was a public responsibility of the proprietary nursing homes and their trade organization to do so.

Realistically, this state and nation must look to proprietary nursing homes as the main avenue, now and in the future, for the nursing home care of the elderly and infirm. Charitably supported homes could not possibly expand enough to do this job. Government institutions would be impractical and costly. Now what does that mean? It means that each proprietary nursing home has a responsibility not alone to itself, but to the general public, and to society as a whole. The Federation of Nursing Homes also has a large responsibility (U.S. Senate, Connelly, 1961, p.546).

This message of private capital meeting a public need was reiterated as the hearings moved on Minneapolis. In his statement, Sidney Shields, President of the Minnesota Nursing Home Association, echoed his Massachusetts counterpart. He stated that proprietary facilities could operate at less cost than government and voluntary facilities, so they could provide better care at less cost. "Commencing with 1951 and 1952, private capital was induced to enter the nursing home field and a new type of modern fireproof building appeared, providing many facilities found only in hospitals," he said (U.S. Senate, Shields, 1961, p.668). At the time of the hearings, Mr. Shields testified, private nursing facilities provided care for a disproportionate number of publicly aided patients and did

so without the stigma of the county home or poorhouse still ascribed to some public facilities (U.S. Senate, Shields, 1961).

In some ways, the nursing home hearings in Minnesota brought the matter of nursing homes and medical care costs full circle. Professor Arnold Rose of the University of Minnesota commented briefly on the desirability of continued nursing home expansion in Minnesota, but also expressed concern for the plight of older citizens who could not pay for nursing homes or expensive medical care out of their own resources. Therefore, he said, he supported a program of social insurance for health care costs paid through the Social Security program at the federal level (U.S. Senate, Rose, 1961).

The 1963 Medicare Proposal

Despite all this effort, medicare still seemed far off. Long before its passage, socially based, compulsory health insurance for elders under the Social Security system was called "medicare". Senator John Kennedy became President in 1960, shortly after the signing of the Kerr-Mills bill. As a senator he had supported aggressive actions on health insurance, personally sponsoring medicare legislation. However, even as President, he was unable to muster the Congressional support to pass such a program. The coalition of conservative, mostly Southern Democrats and Republicans opposing medicare was too strong. Defeated on this issue

again in 1962, the administration moved on to other matters. The New York Times referred to medicare as the "most forgotten of all forgotten issues in 1963" (New York Times, 22 November 1963, p.20). The following day President Kennedy was assassinated. Despite the view expressed in the New York Times, the effort to highlight the need for medicare continued.

Congressional hearings on "Medical Care for the Aged" were used to gain insight into the views of the public and interested organizations regarding the expansion of federally financed health care services beyond Kerr-Mills. Both the Kennedy Administration and interested organizations, notably the AMA, presented information and documents to argue for or against the proposed legislation. Secretary of Health, Education and Welfare (HEW), Anthony J. Celebrezze, provided extensive testimony. He cited anecdotal information about the burden of health care costs on the aged, or worse, the absence of any health care for the poor and old. He presented a HEW document which told what medicare was and what it was not. "It is not socialized medicine. Nor will it lead to socialized medicine." (U.S. House, Celebrezze, 1963, p.168). He also presented a HEW document prepared by Robert J. Myers entitled "Actuarial Cost Estimates for Hospital Insurance Bill." Myers' booklet was intended to show that there had been substantial thought given to the cost aspects of the

program and that a good cost estimate could be made (U.S. House, Celebrezze, 1963). In retrospect, it can be seen that these planning and cost estimates were badly done and inaccurate.

Other advocates for medicare included Representative Torbet MacDonald of Massachusetts who argued that although health services may have been ineffective in the nineteenth century, improvements in health services and technology made them indispensable in the twentieth century. He argued that the strength of our United States society could be demonstrated by using the Social Security system to help care for the old and infirm, rather than reverting to alms and charity.

It is a paradox of our times that the advances of modern medicine, which have helped add 22 years to the length of life, has brought with it what is close to being a crisis in the financing of health care for the aged. First, this vastly improved medical care has swelled the number of aged in the population. Despite the improvements in medicine, illness becomes increasingly prevalent with age. Second, as contrasted with the last century when medical science was not so effective as to be indispensable, today's medical services often spell the difference between life or death. Third, the increasing cost of health care and increasing need for it have not been accompanied by a workable method for financing this care for the aged. (U.S. House, MacDonald, 1963, p.347).

The AHA straddled the fence, arguing for more health care facilities and money but preferring voluntary insurance plans, particularly the use of the Blue Cross-Blue Shield plans with which its member hospitals were already affiliated (U.S. House, Wilson, 1963).

The AMA had not changed its stance, "The AMA opposes HR3920, as it opposed the predecessor bill, HR4222 in the 87th Congress" (U.S. House, Annis & Welch, 1963, p.658). Its 91 page statement detailed the AMA objections to medicare and argued that most elderly people could afford to pay for their own medical care. Since the advent of Social Security, the AMA asserted, the economic condition of the aged was much improved. It said that the King-Anderson bill (the currently proposed legislation) was not needed because Kerr-Mills was already law and was being more widely used each day to help those who needed it. Increasing numbers of the aged were covered by voluntary insurance, the statement said, so social insurance was not needed.

The AMA objected to the fact that the proposed King-Anderson bill was the same medicare proposal defeated in the previous Congress. It objected to the possibility that bureaucrats, who were not medically trained, would establish rules and maintain controls over payments for medical services. Also in its long list of objections were: the government having sole authority to determine reasonable cost; the absence of free choice of physician and

treatment; mandatory payment of a contribution that would really be a tax; the very high overall cost of the proposed plan and the burden it might put on middle class families; the diversion of funds that could be used for the advancement of medicine; the loss of the doctor-patient relationship; and that this sort of medicine was "alien to these shores" and would result in low quality, "assembly line medicine" that would discourage capable people from entering the medical field (U.S. House, Annis & Welch, 1963).

The American Nursing Home Association (ANHA) also objected to the King-Anderson bill. It protested the absence of a means test and the need for hospitalization prior to any nursing home use covered by the proposed plan. The ANHA also objected to the fact that only those costs accepted by HEW would be covered, instead of full charges. It did not want private insurers supplanted by public sector funding and it felt that state and local administration would be better than federal administration of a health program (U.S. House, Beaumont, 1963).

Other organizations like the Group Health Association of America, the American Nurses' Association, and the National Medical Association all supported this legislation. In one way or another they each felt that there was an obvious need for such a program for the old, the sick, and the poor and that the Social Security system was a sound

base for such a program (U.S. House, Medical Care for the Aged, 1963).

Although Kennedy had not been able to pass a medicare bill, he and its many other allies had stirred up extensive debate on the topic. It became an important issue in the 1964 elections. While in the Senate in 1961, Kennedy had called for construction grants for nursing homes as part of his medicare bill, as well as increased research and development funds, additional training funds, maternal and child health funding, and other initiatives. Nursing home elements also were contained in proposed 1962 and 1963 legislation.

Like much that appeared in the medicare proposals, and as well as in the Kerr-Mills Medical Assistance for the Aged statute, many of these ideas had come from Wilbur Cohen (David, 1985; Marmor, 1973).

Cohen is a legendary figure among supporters of Social Security and social insurance in the United States. Cohen had worked on the original Social Security Acts in 1934. He felt strongly about the desirability and appropriateness of social insurance and, along with fellow Social Security experts, Robert Ball and Robert Myers, crafted most of the important changes in the Acts for more than a half-century (Berkowitz, 1987). Their constant influence is a partial explanation of how elements of social insurance spanned one piece of legislation to another, from one Congress to

another, from one administration to another and, in fact, from one era to another. An example of Cohen's importance is that he was able to convince liberal Congressmen to vote for the conservative Kerr-Mills legislation, arguing that it was a stepping stone to medicare (David, 1985). He may have been largely responsible for the transmission of certain Truman administration strategies (such as a focus on health care for the aged) from their origins in 1947 to their successful application in 1965.

Focus on Nursing Homes

Parts of the testimony offered at the 1963 Congressional hearings on medical care for the aged was focused on nursing homes and the services they offered, and gives us an additional perspective on how they were viewed at that time. The proposed medicare legislation defined a skilled nursing facility as one that was part of or had an affiliation with a hospital, existed primarily to provide skilled nursing care, and met certain other criteria (U.S. House, Medical Care for the Aged, 1963). There were some 23,000 nursing homes in the country in 1961 with about 600,000 beds. Only some 9,700 homes with 338,700 beds were classified as skilled nursing facilities, roughly twice the number that had been available in 1954. About 90% had either an LPN or an RN on their staffs (U.S. House, Beaumont, 1964).

William Beaumont of the ANHA described the ownership and custom of these facilities:

I might point out to you at this time that 72 percent of skilled nursing home beds are in private or proprietary nursing homes, and 16 percent in nonprofit nursing homes. Publicly operated homes accounted for only 4.5 percent of homes, and 12 percent of the beds.

The average age of our patients is 80. Most spend at least a year with us, and one third are with us 2 or more years. Many return to their own homes.
(U.S. House, Beaumont, 1964, p.1863).

Parallel hearings were centered on nursing homes without reference to other health care issues. Much of this testimony was delivered by the staff of HEW, who pointed out that, as of 1963, Kerr Mills was experiencing limited acceptance by individual states. There was an obvious need for additional nursing homes of high quality and Kerr-Mills might help fund them if it were more widely accepted. HEW set the need at 500,000 more beds.

HEW staff also outlined the need for uniform licensing standards. Most facilities existing at that time met only the limited federal description of a nursing facility, although all those listed were probably licensed by their states. Some widely accepted federal standard would obviously help to achieve uniformity and a higher standard as the federal government became more deeply involved with

long term institutional care (U.S. House, Long Term Institutional Care for the Aged, 1963).

The Public Health Service (PHS) view of the rapid growth of nursing homes was put forth by the Chief of the Division of Hospital and Medical Facilities, Dr. Harald M. Graning. He said,

Prior to the 1930s, only a handful of nursing homes were in existence. Since that time however, many factors have operated to create serious demands for long term care facilities which would provide economical and effective medical and nursing care for our chronically aged population.

Foremost among these pressures are the much higher ratio of aged persons in an ever increasing population, the shift of our younger and middle aged population groups from hometowns in search of employment or greater economic advantage, and the inadequate space of efficiency housing in the urban and suburban areas to accommodate aging parents and grandparents (U.S. House, Graning, 1963, p.55).

The PHS testimony also highlighted the usefulness of Hill-Burton, following the 1954 amendments, in providing additional nursing home beds. Graning's testimony was somewhat contradictory since he talked about the great importance of Hill-Burton, but then said that Hill-Burton contributed to the construction of about 8,000 beds per year while other sources of financing produced 30,000 beds annually (U.S. House, Graning, 1963).

In its testimony the AMA acknowledged the importance of nursing homes, stated that they are not for the aged alone,

remarked on their improvement, and called for further improvement. In part its statement said:

Nursing homes today are undergoing somewhat the same evolution in patient care as that experienced by hospitals a few generations ago. Much progress has been made in improving the quality of care in nursing homes. In many instances nursing homes can now be stepping stones to a patient's return to his home and family. However, as a whole, the potential of nursing homes as a link in the chain of medical facilities caring for the long term patient has not been fully realized. (U.S. House, AMA, 1964, p.165)

The American Nurses' Association (ANA) also favored more and better nursing homes. Its testimony focused on the need for standards, particularly for nursing personnel. Its statement included seven pages of detailed suggestions for such standards (U.S. House, ANA, 1963).

Ollie Randall, appearing for the National Council on Aging, was more skeptical of the industry in her testimony. She expressed concern about quality in nursing homes and she championed additional efforts to care for the disabled in their homes. She pointed out that the amount that is paid for services, either in the community or an institutional setting, has a bearing on quality, an argument for a fair rate of payment for providers. She shared her view that public facilities, such as county homes, were thoroughly inadequate and did not provide a good solution to the

problems of those in need of care (U.S. House, Randall, 1963).

Richard Stevens, of the National Fire Protection Association, discussed nursing home fires in Florida, Ohio, Massachusetts, Washington, D.C., Missouri, Kansas, and Iowa in which old and disabled people were trapped and killed. He said, "...a recent study by the National Fire Protection Association shows that 223 people died in 41 fires in nursing homes in the period 1953 through 1963" (U.S. House, Stevens, 1963, p. 38). In one fire 32 people died, in another 63 people, in another nine were killed. Disasters like these may sometimes be acts of stupidity or perfidy, he noted, yet it was important to have much more stringent standards for fire safety in nursing homes (U.S. House, Stevens, 1963). Many of the homes that did not meet the fire safety standards set for skilled nursing facilities probably included a large proportion at high risk of fire because they were of old, wood frame construction and had inadequate fire prevention systems.

Concern at the State Level

Like the federal government, the states were active in exploring ways to improve nursing home services. In Massachusetts, the "Interim Report, Special Commission to Study Convalescent or Nursing Homes" was published in 1963. The Commission inspected 150 nursing or convalescent homes,

studied the rules and regulations in Massachusetts and other states, acquired historical and current information and presented a wide range of recommendations for altering regulations and laws that governed Massachusetts nursing homes. As did the 1959 report mentioned by Representative Irene Thresher in her testimony before the Senate Subcommittee on Problems of the Aged, this document reveals a continuing concern for nursing homes and nursing home residents. The 1963 report clearly recognized the problems shared by the states. For instance, in discussing the need for and the nature of state regulation, it quotes a staff report of the Ohio Legislature and regulatory language of the City of New York.

The Interim Report notes that at the time of its publication only five Hill-Burton nursing home projects had been approved in Massachusetts. The Commission decided to promote more extensive use of Hill-Burton in order to expand the number of nonprofit nursing homes in the Commonwealth recommending that they be developed by, or in conjunction with, general hospitals. However, it reports on the experience of Ware Hospital in attempting this:

That hospital built a 40 bed nursing home on grounds, then found that the Welfare Department would pay only \$6.85 per day for patient care, a rate that did not cover operational costs. Facing the alternative of adopting a discriminatory policy of accepting only non-public assistance

patients so as to meet costs, or giving up the nursing home operation, the hospital chose the latter and subsequently converted the facility into a part of its regular hospital operation (Massachusetts Senate, 1963, p. 44).

Elsewhere in its report the Commission acknowledged that proprietary facilities and chains continue to buy existing nursing homes and build new ones. Although there is some suggestion that the proprietary owners may not have been doing the job properly, there is no real attempt by the Commission to explain why for-profits could expand and prosper while nonprofits could not.

Dr. Robert Morris, an academician and social welfare professional, was a member of the Massachusetts Commission back in the 1960s. When asked why nonprofits hadn't grown more quickly Morris said,

There was a doctrine about volunteerism, the nonprofit enterprises were supposed to be pure, and they didn't think it was appropriate to act like a business. So they were a little slow in changing their practices. They didn't want to take chances. They didn't want to be entrepreneurs, because it meant borrowing money sometimes, if they couldn't raise it any other way; or it meant working very hard to raise capital in whatever way they could (Morris, personal communication, 1997)

Other experts with varied backgrounds agree with Morris.

For instance, when asked why nonprofits had not grown more rapidly, Scott Plumb, Director of Government Relations for the Massachusetts Extended Care Federation, said in part,

If you look at nonprofits they tend to be very conservative. I don't say this pejoratively, but they are really not acquisitive, aggressive, growth-oriented companies. That stems from their mission of stability; they usually have huge boards and make decisions slowly. That approach is not going to roll the company over every few months to acquire new facilities because it doesn't match with their mission. The mission may be to take care of Pentecostal women in Philadelphia, for instance (Plumb, personal communication, 1997).

Although these remarks differ, they are compatible remarks by experts with very different perspectives on the issues involved. Nonprofit facilities tended to pursue a relatively narrow mission, accepted risk reluctantly, had to work through a ponderous decision process with their boards and communities, and thus made no attempt to achieve anywhere near the expansion the for-profit industry engaged in from the 1950s to the 1970s. As Chapter 6 will show, the for-profit incentive for expansion was to take advantage of an opportunity, fill a need, and make money.

The 1965 Hearings

Hearings similar to those conducted in the House in late 1963 were taken up in early 1965 by the Senate. The

similarity to the 1963 testimony confirmed the relevance of the data acquired at the earlier hearings. They were conducted by the Subcommittee on Long Term Care of the Special Committee on Aging, and were entitled, rather candidly, "Conditions and Problems in the Nations Nursing Homes." Senator Frank Moss of Utah explained the need for fact finding hearings:

Existing federal programs already are involving us in this field, both because the federal taxpayer is a purchaser of care through public assistance programs and because federal programs are assisting in the construction of new facilities.

It is important, therefore, that our programs be designed to assure the safety and proper care of the patients who are the ultimate beneficiaries of these programs, that they be responsive to the needs of the communities where they are used and in keeping with the most modern developments in the care of long-term patients." (U.S. Senate, Moss, p.1, 1965)

In Indiana, there had been an horrendous nursing home fire, which killed 20 of 34 residents and was widely and sensationally reported in the press. While public officials complained that the press had overlooked these issues in the past, the interest of the media had obviously been piqued by this fire (U.S. Senate, Mason, 1965).

Like fire expert, Richard Stevens, who testified at the 1963 hearings, the Indiana Fire Marshal, Ira Anderson,

recommended improved fire prevention steps. He specifically mentioned the need for all nursing homes to have fire and smoke detectors, as well as automatic sprinkler systems for wood frame structures (U.S. Senate, Anderson, 1965).

Albert Kelly, Administrator of the Indiana Department of Public Welfare, faced other problems. He reported that the cost of nursing home care for the poor was constantly rising and was hard to meet, but providers complained that the cost of ever increasing standards required yet higher rates of payment. "The cost of nursing home care advances continuously," he said (U.S. Senate, Kelly, 1965, p. 37). In 1965, the Kerr-Mills program was just about to start up in Indiana, but despite federal cost sharing, additional funds were still required from the state. What was more, the need for residential care services exceeded supply. The state was looking at licensed boarding homes as a less expensive alternative to the more highly regulated and more costly nursing facilities (U.S. Senate, Kelly, 1965).

As these 1965 hearings moved to Cleveland, similar evidence emerged. Ralph Locher, Mayor of Cleveland, told of that city's struggles to find suitable housing for the disabled elderly. He also mentioned recent, horrible fires in Ohio nursing homes and implied that a large proportion of the nursing homes within the city were substandard.

"Attempts to legislate against these poor conditions have

been painstakingly slow, nearly impossible, considering the needs and cost for such care," he said (U.S. Senate, Locher, 1965, p.96). Furthermore, one inner city activist complained that the nursing home situation was the most deplorable faced by the elderly. Public payments for nursing home services were much too low to provide quality care according to Mildred Barry of the Cleveland Welfare Federation. She called for national standards for nursing homes (U.S. Senate, Barry, 1965).

In summary, Ohio public officials, advocates, and newspaper reporters called for a uniform rate setting process; suggested that the level of payment be related to the service needs of individuals; accused the industry of blocking safety regulations; stated that the industry wanted improved standards but needed more money; argued that higher rates alone would not result in improved care; analyzed the circumstances that surrounded a fire that killed 63 nursing home residents; stated that Ohio could not afford to implement Kerr-Mills; and complained about graft, profit making, and racism in Ohio nursing homes (U.S. Senate, Conditions and Problems in the Nation's Nursing Homes, 1965).

The Subcommittee hearings in Los Angeles and other sites produced similar information.

To summarize the testimony of many witnesses in this way may be efficient, but also may diminish the importance these hearings had. The tragedies that seem to have occurred in every state, together with the continuing financial inability of individual states to provide the institutional services that were needed, remained a glaring national problem.

Medicare Finally Becomes Law

The 1964 elections had returned such a powerful Democratic majority to Congress that the possibility of passage of medicare legislation seemed nearer. In addition, Lyndon Johnson dedicated his great skills of persuasion to the passage of a massive social agenda with medicare at its forefront. As in earlier years, the legislative struggle was long and hard, yet by the spring of 1965 the sense of success could be felt by medicare advocates.

As hearings opened in the House Ways and Means Committee, former Congressman Aime Forand was one of the first to testify. It was Congress' way of recognizing his early effort for medicare when he filed the first bill in 1958 (U.S. House, Forand, 1965).

As usual, the insurance companies, the ANHA, the ANA, and many others testified. Most organizations were either supporting medicare itself or supporting changes in it which would benefit them. The AMA, however, was unreconstructed. It still objected to medicare and its effect on the

authority of physicians, it had not altered its positions.
(U.S. House, Ward, 1965).

In the hearings on the house bill there were important disagreements over the proper extent of nursing home regulation. Testimony focused not only on the need for nursing homes but on the abuses that occurred in them. At least one academic observer has stated that establishing the administrative mechanism for Medicare reimbursed nursing homes was the most difficult part of the Medicare program (David, 1985). Despite these difficulties the Medicare program was passed and became law.

The Birth of Medicaid

The passage of Medicare was not the most important development for the nursing home industry in 1965. The 1965 legislation included three sections: Medicare Part A which provided hospital insurance, Part B, an optional insurance program for outpatient services and Medicaid. Medicaid was an extension of the Kerr-Mills legislation that received limited attention at the time. Medicare A and B became Title XVIII of the Social Security Acts; Medicaid was Title XIX.

Medicaid extended nursing home coverage well beyond Kerr-Mills. It had no dollar limit, and it mandated that all states offer an extensive basic package of benefits

(David, 1985). Medicaid emerged as the driving force behind nursing home expansion that far outdistanced other influences, including Medicare.

Like Kerr-Mills, Medicaid covered a range of health care services, and offered unlimited matching funds to the states for those services. The provision of nursing home services to the aged poor by the states (usually by payment to a provider of services) was and is a requirement of Medicaid. While the federal definition of "poor" is general and has been changed from time to time, based on income and asset levels, Medicaid shares with Kerr-Mills the then unique concept of "medical indigence." That is, if paying medical and other health care bills had made someone poor, that person had the same rights to Medical Assistance to the Aged or, after 1965, Medicaid, as someone who had always been poor. This was particularly important for the aged individuals whose income placed them above the eligibility level for assistance in their state, except for the cost of their medical or nursing home bills (Stevens & Stevens, 1974; Derthick, 1979).

In fact, Kerr-Mills had been law for a couple of years before some of the states understood the benefit of providing care under the federal reimbursement rules. Massachusetts, for instance, transferred 14,000 people receiving nursing home care to the Medical Assistance to the Aged program in 1962. Most of them from the Commonwealth's

Old Age Assistance program. Meanwhile poorer states and states that were reluctant to provide broader benefits for their aged avoided Medical Assistance for the Aged because they did not want to pay the state's share of the program (Stevens & Stevens, 1974; Berkowitz, 1991).

One reason that Medicaid did not receive much attention when it was passed was that it was framed as an extension of the existing Kerr-Mills Medical Assistance for the Aged. It was not seen as a bold new venture into social insurance for health care as was Medicare. Title XIX (Medicaid) was entitled "Improvement and Extension of Kerr-Mills Medical Assistance Program. Unlike the original Medical Assistance to the Aged legislation, however, it funded five mandatory benefits: inpatient hospital services, outpatient hospital services, certain laboratory and x-ray services, and nursing home services. No dollar limit on benefits was permitted, though states could impose limits on the number of procedures, the number of days of care and the like. Additional provisions of Title XIX concerned reimbursement methods and further services. Of importance to the nursing home industry was the fact that Medicaid required every state to offer nursing home services to the categorically and medically needy, payment would be made to the provider of service, and at least half the state's cost would be reimbursed by the federal government (Stevens and Stevens, 1974).

Hearings Continue

Hearings on "Conditions and Problems in the Nation's Nursing Homes" continued after the passage of the 1965 Social Security Amendments, including Medicare and Medicaid. At hearings held in New York City, it was found that the city more carefully regulated its for-profit facilities than nonprofits. Representatives of its nursing home industry did not see the need for this approach or for any additional federal regulation.

Talking about the special requirements on proprietary nursing homes in New York City, Irwin Karassik, executive Director of the Metropolitan New York Nursing Home Association, said about the exceptional regulatory status of New York City's proprietary nursing homes, with some sarcasm,

We take a measure of pride in it and vigorously endorse those portions of our code that pertain to standards of nursing care. We are compelled to wonder, however, why all patients in government, voluntary and proprietary nursing homes in this state do not receive the benefit of such regulation. Why, we ask, should they not all be treated as first class citizens? (U.S. Senate, Karassik, 1965, p. 396).

However, Dr. Ray E. Trussel of Columbia University had a less sanguine view of private enterprise in nursing homes. He told of situations in which grossly substandard facilities were operated in the city as money makers rather

than as places of care. He encouraged stricter regulation. Reluctantly, he acknowledged the role for proprietary organizations in supplying nursing home services in New York. He reported that the need for facilities was extensive and that voluntary and government sectors were not meeting it, largely for lack of capital. He pleaded for additional financial support for voluntary and government construction of nursing facilities from the federal government and Congress. Dr. Trussel also presented for the record a report, "City of New York, Board of Hospitals, Hospital Code Part 1, Proprietary Nursing Homes." This was a detailed set of regulations for nursing homes, comparable to current state regulations. These were the regulations to which Mr. Karassik objected, largely because they applied only to the for-profit facilities in New York City (U.S. Senate, Trussell, 1965).

At the hearings in Boston, John Knowles, M.D., the influential General Director of Massachusetts General Hospital, said that the profit motive was necessary to rapidly develop the capacity that was needed.

Many people have said, the proprietary motive has interfered with the giving of best care to these patients, but I daresay if the profit motive had not held sway we would have very few nursing homes in this country today (U.S. Senate, Knowles, 1965, p.599).

Knowles also provided an explanation for this burgeoning need. He said that it was the changed social

milieu since World War II that made the nursing home ever more necessary. Not only had the United States become a more mobile society, but in the American middle class it was increasingly common for both men and women to work outside the household, leaving no one at home to care for the old and infirm members of the family. As others had, Knowles argued for higher rates of reimbursement for nursing homes, insisted on the need for tighter regulation, and expressed concern about the availability of capital. He also supported the public utility model of regulation (U.S. Senate, Knowles, 1965).

Born in Chicago, John Knowles became a very public figure in Boston, where he was often characterized as "outspoken." In 1961, at age 35, he became the youngest General Director of Massachusetts General, was an advisor to the Kennedy's and was nearly appointed Assistant Secretary of Health, Education and Welfare for Health and Scientific Affairs by Richard Nixon in 1969. The most conservative elements of the AMA managed to have the relatively liberal and sometimes outspoken Knowles' nomination withdrawn.

Knowles felt that a big, liberal government had produced many benefits, but by 1971 the time had come for a reassessment of the next steps. He viewed compulsory health insurance as inevitable. In 1972 he left Massachusetts General Hospital to head up the Rockefeller foundation (Boston Globe, 1969, 1971).

Other witnesses at Boston suggested that nursing homes use only fireproof construction (this became law in Massachusetts), questioned the compatibility of fair wages and profits, denounced absentee ownership, expressed concern that smaller nursing homes were no longer economically feasible, were concerned that large ones were not clinically effective, and that the quality of administration of homes needed improvement. Industry representatives talked about the large numbers of publicly aided residents and asked how rates could be fairly set for a proprietary industry that was supplying a public need (U.S. Senate, Hearings at Boston, 1965). A month after Medicare and Medicaid were signed into law, and 11 months before they were implemented, people were still worried about how the nursing home industry would develop.

Despite all the hearings that were held, there was no extended national debate about the changes that would occur when the more limited Kerr-Mills program was replaced by the Medicaid program with its five mandated services. The limited Medical Assistance to the Aged program and its largely voluntary amendments often had been debated, particularly about cost. Apparently the expensive shift of costs from state programs to Medical Assistance to the Aged had occurred long enough after the passage of Kerr-Mills and had been so limited in number, that the cost shift they

caused was not recognized as a forewarning of potentially huge future costs. From 1966 on, the enormous expense of Medicaid became a perennial problem for the federal and state governments, as were rising Medicare costs.

The cost estimates for Medicaid that had been worked up by HEW in 1965 had suggested that the national outlay would be about \$155 million more than the expenditure for Kerr-Mills. However, when New York state submitted its Medicaid plan in 1966 it alone showed an increase of \$145 million over its Kerr-Mills expenditures. The relatively slow response to Kerr-Mills incentives by the states, together with the additional incentives, including mandatory coverages, provided under Medicaid caused an escalation in cost that no one had predicted. Cost had returned to the center of the welfare medicine debate. By 1968, the expense of Medicaid had become a full blown cause celebre. Equity for the taxpayer began to supersede services for recipients as the most talked about aspect of Medicaid. Despite this there still was reluctance to set limits on total expenditures; instead, procedural requirements were put in place. For instance, states had to have vendor agreements with providers in order to pay them under Medicaid. A full set of regulations for the implementation of Title XIX was not in place until 1969 (Stevens and Stevens, 1974; Derthick, 1979; Berkowitz, 1991).

At the same time that Medicaid and Medicare were experiencing funding crises, scandals emerged. There were systematic problems within the bureaucracy. The Medical Services Administration (MSA) had continuous battles between its Washington, D.C. and regional offices, and there were frequent battles between the federal government, represented by HEW and MSA, and professional and trade groups and various states. Medicaid provided nursing home care as a mandatory service, but in those early years, there was no definition of nursing homes in the regulations. When a definition finally was adopted it caused further confusion (Stevens and Stevens, 1974; Derthick, 1979).

One concern was that Medicare nursing homes, or Extended Care Facilities (ECFs) as they were called in the language of Title XVIII, would need to be hospital based. John Pickens of the American Nursing Home Association (ANHA) worried that the savings that ECFs might create, by moving people out of hospitals, would be lost by making hospitals (which are very expensive organizations) the only providers of ECF services (U.S. Senate, Pickens, 1969). Of course, ANHA viewed hospitals as competitors in this area. ANHA was just one of many organizations that attempted to influence the process as the rules for Medicare and Medicaid regulation were being written and adjusted.

For instance, the AMA and the ANHA did not want nursing standards for nursing homes set too high, while the American

Nurse's Association (ANA) felt that high standards were important. ANA also believed that, in nursing homes, Directors of Nurses should be assured sufficient authority. While ANHA tried to limit the establishment of higher standards, it argued that it would happily support raised standards as long as payments were sufficient to cover the improvements. (U.S. Senate. Trends in Long Term Care, 1969).

Another systematic response was similar to that experienced in 1935 with the original Social Security Acts; capital followed revenue. In 1935, when Old Age Assistance funds became available to those not in public institutions, a vast array of proprietary boarding houses and nursing homes rapidly became available to accommodate the elderly, including many who were former residents of public facilities. By 1971, largely through Medicaid but also through Medicare and other programs, \$1.7 billion was being spent on nursing homes by the federal government; about half of the \$3.4 billion industry. In 1966, the operating cost of the entire industry had been \$1.4 billion, and most of that came from private sources. With the advent of Medicaid and Medicare the scale of growth in the field was dramatic. Furthermore, the expansion of the industry was almost entirely in the for-profit sector.

Most of this growth occurred before the definition of a skilled nursing facility (SNF) had been settled. Regulations were slow in development partly because fewer

than three full time equivalent staffers were available at MSA to write and enforce regulations specific to nursing homes. This added to the confusion (Stevens & Stevens, 1974). For example, one option was to define the Medicaid "Skilled Nursing Home" as the equivalent of a Medicare "Extended Care Facility." However, such a decision would leave the question of what to do with all those nursing homes that were not up to the higher standard that ECFs and SNFs would meet. Much of the definition had to do with the physical plant, but there were also regulatory requirements for in-house personnel and visiting consultants, such as physicians.

With a Republican administration in office in 1970, Congress demonstrated newfound outrage at the bureaucracy's failure to get regulations written to comply with Congressional intent. Senator Frank Moss of Utah asked if the administration was carrying out laws in a selective way because it had not yet established standards for SNFs (U.S. Senate, Moss, 1970). After asking policymakers detailed questions about rules implementation, the Subcommittee on Long Term Care proposed that a schedule and standards for implementation of the necessary regulations be established. The Subcommittee expressed grave concern about the rule making process itself, particularly the role being played by industry representatives. The Subcommittee also expressed concern about benefits being denied after services had been

delivered. (U.S. Senate, Trends in Long Term Care, 1970). By 1971, there was enough public concern and partisan rancor about rulemaking and standards for nursing homes that President Nixon spoke out on the topic. He assured the public and Congress that standards for nursing homes were important, that good nursing homes needed to be supported, and substandard facilities eliminated from Medicare and Medicaid funding (U.S. House, Fleming, 1971).

In the midst of all these systems problems, outright fraud and abuse were occurring in pharmacies, in physicians' offices and in nursing homes. Fire continued to be a serious problem, and salmonella outbreaks in nursing homes became a topic of Congressional inquiry (Stevens and Stevens, 1974; U.S. Senate, Trends in Long Term Care, 1970).

By 1972, Medicaid accepted two levels of care: it acknowledged that the mandatory SNF was much like the ECF, and optional to the states was Medicaid payment for another level of nursing home called "Intermediate Care Facilities" (ICFs). These facilities met a lower standard and included many existing nursing homes. Physical and personnel standards were set at the federal level for each type of facility. Thus the precedent of direct vendor payments as a source of federal regulatory authority was established and shared with state government. State authority was enhanced beyond its licensing function (Stevens & Stevens, 1974).

Federal Regulation Enhanced

In the period covered here, Kerr-Mills, Medicaid and Medicare all became law. The relationship between federal funding of nursing home services and the right of the federal government to regulate those services was established, regulators began to grapple as never before with definitions of different categories of facilities, and the funding for nursing home services was vastly expanded by these laws. The many hearings focused increasing attention on important shortcomings in nursing home services. Safety issues, especially with regard to fire, drew headlines and were reported at hearings in many different parts of the country. While increased regulation helped with other matters, these safety issues were not adequately addressed and persisted as problems. In the next chapter, we will see how increased funding led to a much closer bond between business and nursing homes.

CHAPTER 5

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CHAPTER 6
THE EFFECTS OF MEDICARE AND MEDICAID
ON THE NURSING HOME INDUSTRY

This chapter describes the response of the nursing home industry to Medicaid and Medicare. It also tells how these laws and the industry were constantly criticized as the effects of the laws were felt.

Medicare and, more particularly, Medicaid, brought a whole new, larger scale of operations to nursing homes. Multifacility ownership became more common. Getting loans from the local bank became less important to the big companies as they moved into different and more substantial capital markets to finance nursing home construction, acquisition, and operations. The stock market became the source of capital for national nursing home companies, many of which were dedicated to deriving profits from the Medicaid and Medicare programs.

As these programs developed, scandals emerged and regulation became more pervasive. Eventually, extensive operating rules were written and enforced by the Health Care Financing Administration (HCFA), in response to public concerns about the direction of the industry and the quality of nursing homes. Once again, Congress held an extensive series of hearings on many different aspects of nursing homes and the nursing home industry.

Nursing Homes Enter Major Capital Markets

The marriage of big business and health care in the nursing home industry has not often been widely or publicly discussed, except for the business press. The chief focus of publications such as Business Week, Barrons, Forbes, and Fortune is on profitability or the opportunity for future profitability. Their readership includes those who are trying to invest money for profit. The rhetoric of these profit oriented publications stands in marked contrast to that of nonprofit and public health services providers. The summer after Medicare and Medicaid were passed into law, Business Week published an article which noted that, when financial investors searched the health care market to determine where the Medicare driven bonanza would occur, they discovered that nursing home real estate was a high profit area worth exploring. The Business Week writers expected chain operators to succeed because of their volume purchasing opportunities and their ability to apply powerful financial controls from a central office. They also pointed out that new facilities would be needed as tightened standards closed existing nursing homes (Business Week, 1966).

This article cautioned that Medicare did not allow for much profit in its hospital reimbursement formulas and reported that many owners of one or two nursing homes were

selling out because of marginal profitability. The article highlighted financially powerful new entrants into the nursing home "market," such as Medicenters of America, an offshoot of the Holiday Inn motel chain. It reported that mortgage lending was not adequate for the needs of these ambitious new organizations, so they convinced the Federal Housing Administration (FHA) to guarantee bond issues (FHA had been guaranteeing most nursing home mortgages since 1959). This allowed organizations to escape the constraints of a tight mortgage loan market and receive low interest rates (Business Week, 1966). When intending to expand rapidly it was time consuming for such organizations to apply for a separate mortgage loan for each facility. The bond guarantees permitted these organizations to package the loans for many facilities as bonds and sell them at favorable rates, reducing the effort required to obtain the funds they needed for their expansion plans. In essence, the sale of bonds involves unaffiliated investors making funds available to the selling organization for a set period of time, at specific interest rates, for specified purposes.

By the summer of 1968, the nursing home chains had already gone beyond issuing bonds and entered the stock market to raise capital for the development of new facilities. When a company sells shares on the stock market, they are selling an ownership interest in the

company. Each shareholder owns a little piece of the company. "The stock market...is infatuated these days with companies that operate nursing and convalescent homes," Business Week reported (Business Week, 20 July 1968, p.46), adding that the Four Seasons Nursing Centers of America was operating 11 facilities, had 14 under construction and 28 more planned. Its initial public offering of stock was made in May, 1968, it opened at \$11 per share, and closed at \$23 on its first day. When the article was being written (presumably in mid July), the share price was \$44.75.

The magazine described the operating techniques used by this highly successful (and very new) nursing home organization. Four Seasons insisted that a large part of the financing for each individual facility come from local physicians, to help form a referral base and drive down capital costs at the same time. It hired and trained personnel 30 days prior to opening; it maintained a three to six month training program for administrators; and it constantly searched for new sites and new doctor groups. Four Seasons dismissed concerns about conflicts of interest among its physician-investors as irrelevant. Business Week also described the regional chain of command used to control and support Four Seasons' facilities (Business Week, 1968).

Some New Enterprises Stumble

By 1971, the Four Seasons' chain of command had failed, the company was in Chapter 11 bankruptcy, and its principals

were on the way to jail for fraud (Loehwing, 1973). The judge in the bankruptcy case asked a friend of his to take over the company. The friend, James Tolbert, had an extensive business background including a degree from the Stanford Business school. He sold off the most troubled properties, consolidated profitable holdings, struggled to make the balance sheet work, and diversified into aluminum building products and oil drilling. By 1982, the company was quite healthy and shareholders had a reasonable return on their investment (Rudnitsky, 1982). However, this company had strayed a long way from health care. As the Four Seasons example suggests, people were entering the nursing home industry who had no prior expertise or interest in health care.

The Holiday Inn - Medicenters of America story is another example. The two most senior officials of Holiday Inn were also the two most senior officials of the recently formed Medicenters of America when its newly constructed Medicecenter of Memphis opened next to the University of Tennessee School of Medicine. It expected to provide extended care services for brief periods of convalescence to patients discharged from the medical school hospital. Eighteen months later, Medicecenter of Memphis was filled with long stay, low paying Medicaid patients. The administrator was fired, the low paying patients were shuffled off to less

glamorous surroundings, and the facility was renovated. These corporate managers' lack of experience and interest in nursing services was overcome by the large sums of money made available by Medicare and Medicaid. These floods of cash made up for many errors in judgement (Elliot, 1969).

Despite these two examples and others like them, stock market interest in such companies was strong through the late 1960s. In one case, a nursing home company made an initial public offering of stock when it had no operating staff and no real plans beyond the expressed intent to purchase, build, and operate nursing homes. This firm, Metrocare Enterprises, saw its stock highly valued when it was introduced and used much of the cash from its initial public offering to purchase existing nursing homes from company insiders; people who had put the plan together in the first place (Elliott, 1969).

The process of growing a nursing home business in the generic sense is pretty well known. Scott Plumb, Director of Government Relations for the Massachusetts Extended Care Federation, a trade group, described it succinctly:

The usual premise is that you buy nursing homes and then you keep building your business. You don't build (new facilities) because that takes too long and consumes too much capital, so you keep buying homes until you get to the point where you want to go public. So far you're using venture capital and you're showing growth. As long as you're showing growth the venture

capitalists are happy, then, at some point, you try to go public. This is the model that was probably used by Olympus and Frontier and certainly used by Mediplex, Sun and Horizon. They all did that (Plumb, personal communication, 1997).

Plumb's insights open up the sort of scenario where a businessman might buy a nursing home by using his own assets to secure his portion of a mortgage and he may apply for FHA Section 232 guarantees if the facility will qualify under that program. The individual owner will almost certainly have formed a corporation to own and operate this and future facilities. With a base in place, the corporation will operate the facility and begin to seek additional acquisitions. When an opportunity to purchase an appropriate facility appears, or even earlier, individuals and organizations with money to invest will be invited to be part owners of the new purchase, or to become partial owners of the operating corporation, in exchange for providing the money needed to secure the necessary loans and to provide a cash flow. As the corporation grows it may chose to sell debt by floating bonds to build new facilities. This approach was used in the late 1960s and early 1970s.

A more likely approach, as Plumb suggests, is to go public. In this process, the corporation provides extensive information to regulators, stock exchanges, and underwriters. When these filings and information are reviewed and found to be appropriate, an initial public

offering (IPO) is made. Individuals and organizations who have an interest in investing their money in the corporation may now do so by purchasing shares of its stock. Typically, at the IPO stage, the value of the holdings of the corporation is significantly below the value of income from the sale of stock. This provides a large base of capital (cash) to permit the corporation to grow even more quickly. It may also permit original owners to receive cash by sale of some of their own shares. As long as shareholders are happy, the corporation can grow at a rapid rate. It may float bonds or, more likely, sell additional shares of stock as it requires additional capital for its operations and expansion.

Although nursing homes are a low profit margin business, they have often been low risk as well. What is more, the reimbursement mechanisms have sometimes been skewed in such a manner as to make nursing homes a very profitable real estate investment.

Laurence Branch, now of Duke University described the financial maneuvering of that time:

The reimbursement formula was such that if you owned a nursing home and I owned a nursing home and we sold to each other so we each made a \$200,000 profit, HCFA would have paid us for that new base, never asking whether it was correct or just. They would have just paid us cost plus. So there was a whole era there when it was just good business to buy and sell nursing homes quickly and at a profit so that all the owners would profit from it (Branch, personal communication, 1997).

While changes in the reimbursement formulas have been made to reduce the effect of such activity, a lot of people bought and sold a lot of nursing homes before the changes occurred. Thomas Jenkins is a judge in California who serves on the board of a nonprofit nursing home organization in that state. He was the first Counsel to the American Association of Homes and Services to the Aged (AAHSA) and is a past president of that national organization. Reflecting on the boom days of the 1960s and 1970s, he said,

Bond issues and stocks were the key to what happened in those days. You know reimbursement was highly variable. It was something like \$103 in New York City and more like \$43 in other places. Whether it was \$43 or \$103, it began to occur to business people that there were opportunities for consolidation and profitability.

Some people and companies tried to build new facilities, like the Four Seasons. But others began to realize that buying places which were already operating and had revenue was a better bet. They would go out and buy six or eight nursing homes, then form a company and go public, making lots of money on the stock sale. That's how many of the chains got started (Jenkins, personal communication 1997).

Scott Plumb is a trade association leader in Massachusetts, Laurence Branch, is a long term care researcher in North Carolina and Thomas Jenkins works in California. But their descriptions of how nursing homes garner profits are consistent. Profitability depends on access to capital, constant growth, and a good plan. It was

at the IPO that the original owners of what was becoming a chain of nursing homes realized their first big profit.

Sources of information on the history and development of the chain nursing home are few. At some time, probably in the late 1950s or early 1960s several organizations that had been set in one geographic area and were controlled by identifiable individuals seem to have mutated into very large and somewhat featureless entities. Attempts to gather information about the origins of Beverly Enterprises, Inc, and Hillhaven, Inc., two of the very largest chains, met with little encouragement. Their public relations offices sent current annual reports but denied having much information about their origins. The library and public information office of the American Health Care Association (AHCA, successor to the American Nursing Home Association, ANHA) offer little information about the development of the industry. Congressional testimony by the AMA has made it clear that at one time or another they had a lot of information about all aspects of health care operations, including nursing homes. However, their librarians have been unable to offer any suggestions about how to acquire such data.

Tracking a Nursing Home Conglomerate

However there are sources such as Moody's Industrial Manual, a publication of Moody's Investment Services, the Wall Street financial information and ratings firm. In

Moody's can be found an example of the modern nursing home business in "Beverly Enterprises Inc." It was incorporated in Delaware in 1987 as a successor to a California company of the same name incorporated there in 1964. In 1968 it acquired Scott Drug Co. and sold it in 1971. In 1969 it acquired Lake Shastina Properties and Home Hospital Supply Co. In 1970 it bought United American Corp., Berwyn Convocare Inc., Berwyn Drug Store, and Bercy Industries (manufacturers of personal care products which was sold that same year), Medical Air Products Inc. (sold in 1971), Griffin Printing and Lithograph, J.D. Plastics (sold in 1971), and Towne, Paulsen & Co. (sold in 1972). This pattern of acquisition and disposition went on through the years, although in subsequent years the acquisition of companies outside the long term care and drug industries became reduced in number while the acquisition of long term care and pharmacy operations became dominant (Moody's, 1996).

By 1996, Beverly Enterprise's subsidiaries included long term care operating companies, active in most states; some hospital and transitional living facilities; medical equipment and home health organizations; and a very strong pharmacy component. Beverly owned Dunnington Drug, Instacare Pharmacy, and Pharmacy Corporation of America which were dominant institutional drug providers in many large markets throughout the United States. In addition,

joint ventures with construction and banking organizations based in Japan help to provide much of the financial liquidity this huge corporation requires (Moody's, 1996). Our purpose here is to give some insight into the life of this individual business. Its scale is enormous, its influence extensive. It cares for tens of thousand of disabled people in its nursing homes, rehabilitation facilities, pharmacy operations, and home care entities, but its corporate life is huge and abstract. Management of such an enterprise probably requires the same skills that would be needed if it built strip malls or managed office buildings. This is one face of health care and the nursing home industry and has been at least since the coming of Medicare and Medicaid.

The Negative View of Chain Nursing Homes

Nursing home chains are important to the nursing home industry. About 45 percent of the nursing home beds in the country are owned by chains (MEPS, 1997). According to Laurence Branch "What chains are trying to do is achieve economies of scale by having shared administrative structures. The downside of that is that power does not reside in the individual facility and that leads to depersonalization within the chain facility," (Branch, personal communication, 1997). Branch described a problem he views as systemic to large chains.

Not everyone feels that chains are bound to have problems. Forrest McKerley holds the first administrators license (license #1) issued in New Hampshire. He has been very successful as an owner and operator of nursing homes and owns a chain of them as well as related businesses. When asked if chains deserved a negative reputation he said, "Well, no. We own many homes and do a good job. Beverly went over a thousand homes at one point, and it was too big for them. They did it just to get big and it was too much. They sold off a lot of their older or troubled homes and they are coming back. They are doing a much better job" (McKerley, 1997). McKerley obviously feels that some chains do well, but shares Branch's perception that size can be a problem.

In the matter of nursing home chains nearly all the experts interviewed for this study agreed that the public has some doubts about nursing home chains. Branch and McKerley appear to agree that, as an organization grows larger its care-giving mission becomes tougher. Although expressed in many different ways, that view was held by many of the experts we interviewed.

In the late 1960s, a blue ribbon panel was formed to study the impact that nursing home proliferation might have in Philadelphia. The most immediate, and obvious concern the panel found was the fear that over capacity would result

from rapid construction of facilities by "gold rush" business organizations being fed capital by the stock market. However, the study also noted that although there was over capacity in Philadelphia in 1965, it disappeared with the arrival of Medicare (Elliott, 3 March 1969).

Feeling the Effects of Medicare and Medicaid

Neither Medicare nor Medicaid reimbursed nursing homes at a very high rate (compared to private rates). However, within a few years they were serving many more people than may have been projected and became more costly than had been estimated or intended. Because of this great public expense, state and federal officials considered cutbacks in these programs. At the same time, however, private industry was enjoying a bonanza in a business that originally had been funded with the view that it would be like the voluntary model set by hospitals. Even Governor Nelson Rockefeller of New York, a steadfast defender of aid to the poor, recommended draconian cutbacks in the Medicaid budget. Only one in four nursing homes had sought Medicare certification in the early days of the program, but by 1969 30 or more national chains applied to serve the Extended Care Facility program (Elliott, 1969).

In October 1965 the Boston Globe reported on the implications of the "Medicare Revolution."

Medicare is going to change things so drastically that many operators of the 714 nursing homes in the state have been thrown into a panic.

Under Medicare, nursing homes will have to be linked with hospitals. National boards of accreditation are being organized to establish standards. The federal government will be interested in the quality of care.

This provision is going to change much of nursing home care from a custodial approach to shorter term treatment and efforts at rehabilitation.

These factors make it evident that the small nursing home run by a nurse who came out of retirement will have a hard time surviving.

It is hoped that those sub-marginal homes which have caused investigations into maltreatment of the elderly will not last. And for this, all operators of legitimate, well run nursing homes will be grateful (Coeb, 1965, p.A1).

As is sometimes true of newspaper reports, this article took literally the language of supporters of the Medicare bill around the time of its passage. These events did not occur in the short term, but over the 30 years since the passage of Medicare and Medicaid, much of what was predicted by Coeb has come about. Although there are still nursing homes that are not linked with hospitals, even these nursing homes often look like hospitals. There are still some small nursing homes and some of them are run by nurses, but not many.

For-Profit and Not-For-Profit and Why

Throughout the Medicare and Medicaid era, there has been a concern about the rapid increase in for-profit and chain nursing homes compared to independently operated, nonprofit facilities. At one 1979 hearing Congressman Thomas Luken of Ohio asked Laurence Lane, Public Policy Director of the American Association of Homes for the Aging, about these differing rates of growth. After Luken confirmed that Lane represented nonprofit providers, he asked why Lane was arguing to include a financial return on equity in the Medicare reimbursement formula. Lane answered that the original Social Security Act of 1935 had undermined the publicly sponsored nursing home and supported private facilities instead. Other laws in the 1950s, particularly Kerr-Mills, made an allowance for a financial return on equity for proprietary organizations but not for nonprofits. Lane said that nonprofits required a financial return on equity, not just a capital allowance, in order to be able to develop. The absence of return on equity effectively prevented, in some cases, the not-for-profit facility from growth and development (a return on equity is a rate setting tool which permits a profit to be made on an investment, a capital allowance is simply a reimbursement for cost). Lane noted that a recent study had indicated that if further incentive for development were not put in place for both

profit and nonprofit organizations, a shortage of facilities and services would result (U.S. House, Lane, 1979).

Whether capital allowances and returns on equity have similar or very different effects on organizations and markets is largely a technical accounting issue. However, there have been a number of academic and popular articles on the differences between for profit and not for profit facilities. Some elder advocates and academic figures, such as Ollie Randall and Arnold Rose, felt that profit making facilities were less desirable than nonprofits because the profit motive led to a lower quality of care. However, the industry from the 1950s on, and particularly during the Medicare and Medicaid era, has become more dominated by for-profit facilities (Appendix A).

Research into nursing home ownership types and the differences among them has produced mixed results. Lemke and Moos found that not-for-profit nursing homes offered a somewhat more comfortable physical and social environment, while Veterans Administration facilities offered a more extensive range of services but less resident autonomy. They noted the difficulty of comparing ownership types because of the other variables that exist, such as, level of care, resident acuity, resident disability levels and facility size. Lemke and Moos also found that residents of nonprofit facilities had greater social rapport, getting

along better with each other and staff. Which may cause the reader to wonder if that is partly because nonprofits are often operated by organizations committed to some level of cultural affinity (Lemke & Moos, 1989).

Riportella-Muller and Slesinger found that smaller nonprofit homes had fewer annual certification survey violations than did small proprietary homes. However, the larger nonprofits had more survey violations than the larger for-profits. Riportella-Muller and Slesinger's interpretation is that the greater efficiency of for-profit homes may increase their effectiveness in serving larger numbers of residents (Riportella-Muller & Slesinger, 1982). Spector and Takada reported that for-profit ownership was significantly and negatively related to resident death; however, they concluded that this association of ownership and mortality was not necessarily related to quality. It may have been the result of resident selection and other issues. The statistical significance of for-profit ownership regarding death rates is lost when functional change in residents is used as a measure. As have other researchers, Spector and Takada found that for-profits are more efficient users of resources than are nonprofit nursing homes (Spector and Takada, 1991). However, Tuckman and Chang implied that sharp competition in a market will drive

the efficiency of nonprofits upward toward that of proprietary facilities (Tuckman and Chang, 1988).

Arling, Nordquist and Capitman reported that for-profit chains not only were the most efficient operators of nursing homes, but that they were also the operators with the highest percentage of Medicaid residents in their facilities (Arling, Nordquist and Capitman, 1987). This may imply that the low but certain reimbursement from Medicaid was more economically efficient than was the expensive struggle to attract more private pay residents. Independently owned for-profits had the highest private pay census. Nonprofits ranked in the middle between the chain and independent proprietary groups with regard to payer mix.

Baldwin and Bishop directly addressed the issue of public support of profit making in nursing home operations. They pointed out that higher profits in the industry may lead to more for-profit operators and more nursing home chains. They alluded to the unproven, but widely held belief that nonprofit and locally owned facilities provide a higher quality of care and are more desirable than chain operations. At the same time, they demonstrate that Medicaid and Medicare have contributed to situations in which chain operations thrived and own an ever larger portion of nursing homes because of their substantial capital capacity. This occurred despite rules in some

states that limit potential profits from nursing home real estate transactions, required certain levels of capital investment in each property, or clearly favored nonprofit operations (Baldwin & Bishop, 1984).

Hearings Focus on Nursing Home Quality, Medicare and Medicaid

As Medicare and Medicaid came fully on line, adjustments were necessary. A variety of problems soon were apparent and once again Congress started a series of hearings. Hearings were held by the House Special Committee on Aging, the Senate Special Committee on Aging, by joint committee hearings before both houses, and by other Congressional bodies from the late 1960s through the mid-1980s. While new information emerged in some hearings, a pattern of tedious repetition of continuing concerns was more typical.

In Connecticut the Subcommittee on Long Term Care of the Senate Special Committee on Aging held hearings under the direction of its Chair, Senator Frank Moss. Testimony described discrimination against Medicaid recipients in nursing homes, inadequate standards for intermediate care facilities (permitted under 1967 amendments to Medicaid), the failure to collect relevant data about the industry (how many "chains" or multi-facility owners are there?), and a general perception that both nursing home standards and the

levels of compliance with those standards were low (U.S. Senate, Moss, Laughlin, DePreaux & Hutton, 1969).

Also before Moss' subcommittee, ANHA objected that HEW wanted higher standards but not higher reimbursement levels. The desire for high standards and low cost was described as perverse, and the implication was that such a hope was unrealistic. Eleanor Baird of the ANHA said in her testimony:

It is academic to say that high standards cost more money than lesser standards. The Federal Government has demonstrated in its administration of the Medicare program that it wants high standards. But, perversely, it has also demonstrated that it is unwilling to provide adequate reimbursement to pay the cost of high standards. Instead, through its regulations, it passes on part of the cost to the extended care facility and another part to the private paying patients. (U.S. Senate, Baird, 1969, p.88-89)."

Cost concerns were expressed in other ways. With the Moss subcommittee back in Hartford the following year, a Connecticut legislator blamed the Nixon administration for denying Medicare nursing home services to patients who could not positively document rehabilitation potential. Edward Marcus, the Connecticut State Senate majority leader said,

I wish to vehemently protest the cutbacks in the Medicare program which affect the health and welfare of so many of our over 65 citizens. At least 40 percent of the over 65 patients presently served under the Medicare program will no longer have

their expenses paid by the Federal Government (U.S. Senate, Marcus, 1970, p.264).

Retroactive denials of payment for Medicare services that had been provided weeks and months earlier also became a bone of contention between advocates for the nursing home industry and the federal administration (U.S. Senate, Offenkrantz, 1970).

While the failure of Medicare to pay for everything everyone had thought would be covered led to controversy, so did profiteering by nursing homes. The president of the Connecticut Association of Extended Care Facilities remarked on the unprecedented growth of nursing homes in his state. The startling growth occurred because of "an apparent bonanza, promising lucrative returns on dollar investments" promised by Medicare (U.S. Senate, Dellafera, 1970, p.275). The Association welcomed alternative rate structures, reimbursement systems that separated different levels of care, and limits on facility construction as ways to control such growth. "It should be further recognized that there can be a good marriage between the provider of nursing care service and a fair reimbursement schedule (U.S. Senate, Dellafera, 1970, p.278).

Fire remained a major problem and may have been the most dramatic example of the need for new and higher standards. Back in Washington testimony before the Moss

subcommittee showed that on 9 January 1970, 43 of 46 patients of a Marietta, Ohio, nursing home were seriously injured or died in a fire. There still were not well defined, minimum fire safety standards for nursing homes. Once again, automatic sprinkler systems were suggested to prevent loss of life or major injury in nursing home fires. These systems could limit the spread of fire and the production of toxic fumes that cause much death and injury (U.S. Senate, Moss, 1970).

The delay in establishment of federal standards for fire protection not only led to continuing tragedy, it also could work a hardship on facilities in states where state standards were in place. When federal rules finally went into effect on 1 July 1973, they demanded fireproof construction and elevators for multi-story buildings. This created havoc in Massachusetts where the state, eight years earlier, had set forth regulations that permitted continued use of frame construction but mandated the use of automatic sprinkler systems. Charles Kelley of the Massachusetts Federation of Nursing homes argued that all 670 nursing homes in the state were sprinklered and ought to be permitted to continue in operation.

Seventy-five percent of the nursing homes in the state are of wood frame construction and would be forced to close by the new code according to Sidney Neustadt, Federation past president

and state chairman of the life safety code and construction standards.

If the code were rigidly enforced, 20,000 patients would be uprooted and sent some place else, but there is no place else to go," Neustadt stated. (Dietz, 1973b, p.32)

There was also a shortage of beds in Massachusetts at that time (Dietz, 1973a).

The response of the nursing home industry to calls for higher standards was predictable. Industry representatives agreed to the need for high standards, but insisted that Medicare and Medicaid pay for the improvements (U.S. Senate, Regan, 1970). It seemed that every public speaker supported improved care services and higher standards, but some things, like fire safety rules and sprinklers did not become a national standard for years; possibly because neither industry nor government would pay for them.

The Regulation Gap

In 1969 Richard Nixon became the first Republican President since Eisenhower, while the Congress remained in the hands of the Democratic party. At this time there was great tension between the Medicare and Medicaid laws and the lack of regulations to enforce those laws. Frank Moss of Utah as Chair of the Subcommittee on Long Term Care of the Senate Special Committee on Aging had shepherded his namesake "Moss Amendments" through Congress. The amendments

were to raise the standards of skilled nursing facilities, require the medical review of each patient's care in a skilled facility supported by Title XIX funds, and establish fire safety standards. In the spring of 1970 Senator Moss publicly complained that the Nursing Home Amendments of 1967 had not been implemented by HEW. "Are Government officials asserting a right to choose which laws they will obey and which they will not?" Moss asked (U.S. Senate, Moss, 1970, p. 623)

HEW and its Medical Services Administration (MSA) answered that it supported the higher standards and realized that the payment of federal funds to the affected facilities gave it authority to set and enforce such standards. However, MSA argued it was so understaffed and so without direction that it had been unable to cope with its rulemaking responsibilities. The Republican administration took this opportunity to point out that a significant portion of the time for working on the changes occurred during the Johnson administration (U.S. Senate, Kimball, 1970).

The Moss sub-committee then asked MSA for deadlines by which it would be able to provide the required regulations and enforcement. MSA apparently was in such chaos that it could not respond positively to this request (U.S. Senate, Moss, Halamandaris & Kimball, 1970). An example of the MSA

response was given by Arthur Newman, Commissioner of the Medical Services Administration in response to a request for a deadline for the implementation of the 1967 standard " I would hope the effective date would be the date of the regulation; however, I don't feel I can make the commitment at this time (U.S. Senate, Newman, 1970, p.639). Although this interaction could be viewed as essentially partisan in nature, the explosive growth of Medicare and Medicaid lends credibility to the possibility that the bureaucracy was not prepared to deal with the many changes that were occurring.

For those distrustful of the nursing home industry, one disturbing outcome of the 1970 Moss subcommittee hearings was the disclosure that not only the American Nursing Home Association (ANHA), but also the American Hospital Association, the American Nursing Association, and the American Association of Homes for the Aged (AAHA) were all deeply involved with the Social Security Administration in developing the new regulations (U.S. Senate, Levy, 1970).

The Hearings Go On

The Moss subcommittee hearings entitled "Trends in Long Term Care" continued through 1971. Old issues kept coming up but new ones also appeared. When HEW officials acknowledged that their enforcement efforts were lagging, they explained that having to enforce different regulations for Medicare and Medicaid complicated the task. It seemed

clear, however, that the Nixon administration was committed to improving nursing homes. In Chicago on 25 June 1971 President Nixon had said, "I do not believe that Medicaid and Medicare funds should go to substandard nursing homes in this country and subsidize them." (U. S. Senate, Fleming, 1971, p. 13)

The administration had discovered that enforcement of nursing home standards was only as good as each state wanted it to be and that HCFA had to depend on state inspectors to do this work.

It has been our experience that the only way that you can get enforcement is to have a cadre of State people explicitly financed and put on this operation, doing this 100 percent of the time, following up identified deficiencies, providing technical assistance, reporting back and keeping the pressure on." (U.S. Senate, Hess, October 1971, p.1981)

There was great variation in the number of inspectors and the level of enforcement from state to state. HEW announced an increase in staff for overseeing state inspectors. In addition, President Nixon ordered the training of 2,000 more state nursing home inspectors (U.S. Senate, Veneman, October 1971).

In some states enforcement of existing standards occurred at a low level because there were not enough nursing home beds. When there was 100 percent occupancy and

long waiting lists, regulators were reluctant to limit bed supply through aggressive enforcement.

Another problem that emerged was the excessive use of institutional care. Since funds were available for such care, it was sometimes used even when other services might have been more appropriate. This practice may have contributed to the perception that far too much "warehousing" of disabled, older people was occurring. The term "warehousing" referred both to the inappropriate placement of disabled people in nursing homes and the failure to provide therapeutic services in those facilities.

Unneeded Doctor's Visits

Another concern was physician visits that were too infrequent and showed poor quality of care. In other instances physician visits were too frequent, yet little actual care was given. In these cases, the presence of the physician was simply to bill Medicare or Medicaid for a service that may not have been necessary or provided (U.S. Senate, Hess, 1971).

Concerns about inspection and enforcement of regulations were widespread. When the Moss subcommittee hearings moved to Chicago, the Better Government Association and reporters of the Chicago Tribune testified that they had conducted joint impromptu inspections of a number of Chicago nursing homes. This group found that the homes' inadequate

physical plant, staffing limitations, poor training and procedures, misuse of drugs, and financial and other problems caused them to operate well below standard. Their efforts highlighted the kinds of issues that had risen in other places, but with the help of the Chicago media, they got considerably more attention (U.S. Senate, Percy & Hutton, 1971).

While the task force found that a few homes are very good and that many are adequate, it also found an inordinately large number of homes unfit for anyone - let alone helpless and chronically ill elderly people. (U.S. Senate, Percy, 1971, p.1421)

Nursing home "chains" were becoming more common in the 1970s. Such syndicated ownership was viewed negatively by the Chicago Better Government Association, John McEnerney testified on behalf of the Association:

The "syndicate theory" has gathered strength and credence as our investigators have gone through a long list of nursing (home) ownership supplied by Dr. Yoder to the Senate committee. Four points should be made:

- (a) A small group owns a great many nursing homes.
- (b) These homes and their operation are connected by virtue of interlocking ownership or interlocking directors.
- (c) These homes, as we saw at the last hearing, seem to be able to make extremely high profits while at the same time the homes or their representatives are constantly pushing the state for higher rates.
- (d) The same homes have been identified by the State and city as being continually

in violation of State standards. Clearly, the homes owned by this syndicate are among the worst in the State. Their motive seems to be making money at the expense of the most under represented minority group in our society. None of us, Mr. Chairman, condemns the profit motive which has helped build this country. However, we do vigorously condemn profiteering. The spectacle of those living the good life at the expense of the sick and dying certainly deserves the contempt of all good men everywhere. (U.S. Senate., McEnerney, 1971, p.1468)

In its report, the Association further pointed out that the economic realities of the nursing home industry encouraged such an outcome. Through the Small Business Administration and the Federal Housing Administration (FHA), the federal government provided low cost loans for both construction and operation of nursing homes. Once built, each home was all but guaranteed an income through the Medicaid program. An average return on investment of 44.9 percent in Connecticut was cited as an example. The Chicago Association's testimony included a chart showing a single interlocking ownership that controlled dozens of Illinois nursing homes (U.S. Senate, McEnerney, 1971).

What the report does not explain is why such multiple ownership of facilities was hidden from the public. One possibility is that the ownership was "churned" in order to drive up the book value of these properties. The nursing homes may have been "sold" every 12 or 18 months within the

clandestine ownership syndicate at a higher price each time, in order to support a larger mortgage loan that, in turn, would provide the syndicate with more cash to purchase more facilities under FHA guarantees. Such a scheme would also permit a higher reimbursement rate if cost based reimbursement were used (U.S. Senate, Recktenwald & Wood, 1971).

Rewriting the Regulation

Finally, in 1972, Public Law 92-603 was passed. It required the integration of Medicaid and Medicare regulations for skilled nursing facilities. When the Moss Committee met to consider the new regulations, there was some dissatisfaction with the fact that providers may have had greater access to the rule making process than the advocacy community, or possibly, the Congress. For one thing the industry had early access to the rules themselves. Representative Robert Steele testified,

Thus the public, aging and consumer groups, and even members of Congress had 30 days to evaluate and develop their positions on the proposed regulations while health care providers had up to 6 months. (U.S. Senate, Steele. 1973, p.2544).

The Moss subcommittee was critical of the new regulations because in some matters they seemed too lenient. For instance, the registered nurse coverage that was

required seemed inadequate to some observers. The American Nursing Association, in particular, felt that the role of nurses in extended care facilities should be expanded (U.S. Senate, Schwab, 1973).

Senator Moss was troubled by the levels of care set by these new, integrated regulations, because they could let some facilities avoid higher standards he favored. "There was unanimity that the new regulations are vague generalizations of past standards which will be a nightmare to enforce....," he said (U.S. Senate, Moss, 1973, p. 2717).

ANHA did not mind that intermediate care facilities were permitted by the new regulations. ANHA was concerned about the very low level of payment that many states would make to these old fashioned nursing homes. ANHA feared that such low income would cause these nursing homes to remain inadequate. Therefore, ANHA agreed that integration of the Medicare and Medicaid skilled nursing regulations would be beneficial, especially if the separately regulated intermediate care facilities were properly funded by states under the Medicaid program (U.S. Senate, Barry, 1973).

Three years after the Medicaid and Medicare nursing home regulations were to be integrated, at a 1975 hearing at New York City Senator Moss rhetorically asked, "What's wrong with nursing homes? Why won't the system work? (U.S. Senate, Moss, 1975, p. 2873). As a partial answer, he

listed five root causes of nursing home problems: 1) federal and state governments had no consistent, coherent policy regarding treatment of residents; 2) physicians avoided nursing homes and their visits were too infrequent; 3) there were too few nurses in nursing homes; 4) Medicaid reimbursement programs favored poor care; and 5) the inspection system did not work (U.S. Senate, Moss, 1975).

The New York hearing focused on the manipulation of the reimbursement system by the Bergman family to achieve unfair profits from the facilities they owned around New York City. As had the Yoder family in Chicago, the Bergmans had an interlocking ownership of a large number of nursing homes.

The New York Medicaid system permitted a 10 percent return on equity. By churning sales, the Bergmans inflated the dollar amount of their equity holdings and thus fraudulently inflated the return on their equity, one of the few areas where profit was allowed under the Medicaid reimbursement formula. Financial audits of nursing homes in New York were so rare that this pattern of fraud went undiscovered for some time.

Here the profit is only based upon the amount of equity in the business, so that in the event that you double your costs in any given year, you would not necessarily double your profit, but you would increase your equity. (U.S. Senate, Moan, 1975, p.2891)

In addition to the financial deceit, inspectors also found nightmarish care practices in the Bergman facilities and others like them. Scalded patients, terrible sanitary conditions, a lack of recreational activities, urine-stained and soaked garments, and a very limited availability of registered nurses were described at the 1975 hearings (U.S. Senate, Jarvis, 1975).

Fraud and Abuse Reaches Beyond Nursing Homes

In the late 1970s, hearings held by the Senate on Medicare and Medicaid frauds examined financial cheating in nursing homes which went beyond real estate transactions. Prominent were kickback schemes from pharmacies and other vendors and the misappropriation of patient account funds.

But nursing homes were not the only sites for Medicaid and Medicare fraud. Chiropractors engaged in false billing and medical clinics paid kickbacks to laboratories and provided unnecessary services for which Medicaid and Medicare were billed. In some cases, perfectly healthy family members who accompanied patients to a clinic received unnecessary services from several of the clinic's providers (U.S. Senate, Medicare and Medicaid Frauds, 1976). Such fraud was so widespread that when pharmacists were polled about kickback arrangements with nursing homes, 15 percent knew of such arrangements, and some admitted participating

in them as a necessary part of doing business (U.S. House, Committee Print, 95-9, 1977).

In addition organized crime was involved in Medicare and Medicaid fraud and such racketeering was widespread (U.S. Senate, Fraud and Racketeering in Medicare & Medicaid, 1978). Unfortunately, advocates for the elderly and disabled made little distinction between legitimate and felonious profit. In Chicago the Better Government Association (BGA) joined with a local TV station to follow up its earlier investigative efforts. Its report described widespread fraud and patient abuse. BGA's President, Marjorie Benton said of nursing home operators: "They should not profit at the expense of the old and the poor" (U.S. Senate, Benton, 1978). She did not address the issue of profiting by the proper and appropriate provision of services.

The Continuing Need for Better Fire Protection

A Congressional report, "Saving Lives in Nursing Home Fires" written in 1971-1972 had concluded that the single greatest step to prevent deaths from nursing home fires was the installation of automatic alarms and sprinkler systems (U.S. House, Report 92-1321, 1972). Some states had such a requirement. Nonetheless, when a joint committee of the House and Senate held hearings in Chicago in 1976, more terrible stories of death and disability resulting from

nursing homes fires were presented. Joint Committee Chair Claude Pepper in his opening remarks, underscored the fact that most of the fires to be investigated by the joint committee could have been avoided or much reduced in their effect by the use of automatic sprinklers. He said, "Evidence to date from Chicago fire officials and others indicates that sprinklers throughout the facilities would have avoided the multiple deaths which occurred." (U.S. Congress, Pepper, 1976, p.5).

The General Accounting Office studied the problem and concurred with the Chairman's statement. The accounts of the fires were similar to those presented years and even decades earlier. The rapid combustion of materials caused extensive smoke and heat. The poisonous gases, limited visibility, and patient's disabilities resulted in many deaths. In the Cermak House the fire never went beyond the room it started in and the immediate hall. However, more than 60 feet away in another room, far from the heat and flames, several residents died from smoke inhalation. Improved barrier techniques such as fire doors limited the extent of the fire, but automatic sprinklers would have reduced both death and injury. The principal reason given for not having a requirement for automatic sprinklers in nursing homes was said to be the cost, estimated to be

between \$400 and \$625 per bed at facilities in Ohio and Minnesota (U.S. Congress, Joint Hearing, 1976).

Using the highest cost per bed, the monthly cost of amortizing \$625 over a 20 year period with a 9.25% interest rate is \$5.57 per bed month or about \$.19 a bed day. (U.S. Congress, Martin, 1976).

In 1979 the House held its own hearings into nursing home problems. Representative Pepper's opening remarks once again highlighted the desirability of having automatic sprinkler systems in nursing homes. Testimony highlighted other concerns that must have been painfully familiar to the members of the subcommittee. They included infrequent and inadequate physicians visits, the use of drugs to control patients, inadequate numbers and quality of nursing personnel, lack of supplies, lack of training, and unnecessary regimentation of residents' lives. Most of the complaints had been voiced in hearings in the House and Senate, as well as in newspapers and magazines from the 1950s on, yet, they continued (U.S. House, Pepper, 1979).

'87 OBRA Brings Tough Regulations

As the 1980s arrived, Congressional hearings continued to focus on shortcomings in the services provided for older people and problems in nursing homes. They included such hearing titles as "Fraud Against the Elderly," "Drug Abuse in Nursing Homes," "Problems of Nursing Home Bed

Availability and Placement," and "Health Quackery." Hearings were held to consider the elimination of the three day hospital stay that was necessary for any Medicare reimbursement for nursing home services. Quality issues were considered in hearings titled "Long Term Care for the Elderly in Florida," "Nursing Home Survey and Certification: Assuring Quality Care," "Discrimination Against the Poor and Disabled in Nursing Homes," and "Quality of Care in Nursing Homes." Like all the hearings which came before, these hearings created a mass of policy information, public awareness and concern that set the stage for change.

However, it was the publication of Improving Quality of Care in Nursing Homes by the Institute of Medicine (IOM) of the National Academy of Sciences that led most directly to radical changes in the regulation of nursing homes. The year after it was published, The Nursing Home Reform Act was passed as part of the Omnibus Budget Reconciliation Act of 1987 ('87 OBRA). The '87 OBRA statute contained a series of regulatory changes that at last drastically altered nursing home practice and operations.

The IOM volume was the product of the Committee on Nursing Home Regulation, 20 experts from various disciplines, backgrounds and geographical areas that had been formed in response to the long running controversy over

nursing home regulations. In 1982, the Health Care Financing Administration (HCFA) had proposed a number of changes in nursing home regulations that many advocates for nursing home quality viewed as being counter to consumer interests. The resulting controversy led to the formation of the IOM expert committee.

The IOM panel gathered information from a variety of interested parties in many different parts of the country. It studied how states regulated nursing homes, how Medicaid payments were made, staffing patterns and personnel issues, the roles of residents and their advocates, and management incentives in nursing homes, among other issues.

The stated purpose of the committee was to propose actions that might overcome years of questionable practices in the nursing home industry. The committee made extensive recommendations in four areas: "Regulatory Criteria," "Monitoring of Nursing Home Performance," "Enforcing Compliance with Federal Standards," and "Other Factors Affecting Quality of Care and Quality of Life in Nursing Homes." It also suggested areas for further study. Many of the recommendations were radical and many had been discussed or attempted in the past.

Under "Regulatory Criteria," the IOM recommended that the regulatory differences between skilled nursing facilities (SNFs) and intermediate care facilities (ICFs)

should be eliminated and that the ICFs should be brought up to the SNF standard. It also said that regulatory activity should center on the residents' needs and not on ease of measurement, that quality of life standards should be elevated in importance to become conditions of participation, that residents' rights should be elevated in importance and carefully specified (particularly around medication and restraint issues), that seven areas of regulatory review should be consolidated and called simply "administration," and that the requirements for both the physical environment and social services should be strengthened.

Under "Monitoring Nursing Home Performance," the IOM panel recommended that the survey process for Medicaid and Medicare be the same, that the timing of these surveys be made less predictable, that a short or sample survey process be used to trigger a more detailed examination of a facility if it revealed problems, that the survey process should be keyed to resident assessment protocols (the central clinical document for each resident), that the survey team should seek input directly from residents, and that inspection of the actual process of care should be integrated into the survey.

Under "Enforcing Compliance with Federal Standards," the IOM recommended the use of enforcement steps such as

closing admissions, civil fines, receivership, forced closure, and the transfer of residents. Such sanctions would be especially appropriate in the case of repeat offenders, nursing homes that showed the same deficiencies in their surveys year after year. It also recommended that HCFA should work to strengthen state enforcement capabilities.

Under "Other Factors Affecting Quality of Care and Quality of Life in Nursing Homes," the committee recommended that HCFA require that all nursing home inspection and cost reports be made public. It also recommended that existing ombudsman programs be strengthened at both the state and federal levels.

The IOM committee suggested that information systems, bed supply issues, and the use of single rooms in nursing homes be studied further (IOM, 1986).

The IOM report and its recommendations received powerful political recognition when it was published in 1986. The following year '87 OBRA included the bulk of the committee's suggestions in its "Title IV, Subtitle C - Nursing Home Reform" and the attendant regulations (42 CFR 483). Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs) were not held entirely to the same standard, but the differences between SNFs and Nursing

Facilities (the term now used for what had been ICFs) were reduced. Most of the other recommendations were adopted.

The most direct influence on '87 OBRA was the IOM report, but nearly two decades of hearings and administrative efforts also were involved in bringing the extensive regulatory structure of '87 OBRA into existence.

In the 1990s, the growth of nursing home chains continues and the introduction of '87 OBRA requirements causes controversy. A recent issue of a nursing home industry trade magazine reported that the American Health Care Association has joined a suit in federal district court against HCFA for its introduction of the survey and enforcement requirements of '87 OBRA.

In the same issue, a list of 44 publicly traded nursing home companies provided their stock market symbols, the exchange they are traded on, recent stock price, price earnings ratio, and high and low prices for 1996 (Provider, 1996). This is a long way from an independent registered nurse opening her house to care for a few disabled elderly people or a New England village taking up a collection to care for an old or sick member of its community.

CHAPTER 6

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CHAPTER 7

REVIEW AND ANALYSIS

Review of the Chapters

The introductory chapter presents the principal research questions: 1) Why are most nursing homes privately owned? 2) Why are most privately owned nursing homes owned by for-profit rather than not-for-profit entities? This study uses an historical review of practice and policy to explore and explain these ownership phenomena. Weisbrod's three sector model of public, private for-profit and private nonprofit sectors is used to characterize these organizations and assist in answering the research questions.

The development of the nursing home industry and the development of government policy toward nursing homes have broader implications for the future of long term care. As will be shown later in this chapter, home care and home health services as well as nursing home services may need to be dramatically expanded in coming decades. Has the history of the nursing home industry taught us lessons that may be applied more broadly to the future of long term care?

Chapter 2 reviewed the evolution of care for the old, sick and poor from the Colonial era through the nineteenth century. Most people were cared for in their homes throughout this lengthy period. For those cared for outside

their homes there were changes in the manner in which care was provided. Community care gave way to almshouses and workhouses. Special care facilities were established for those with specific diseases or disabilities and, later, hospitals became important sites for acute care. The medical profession and modern nursing emerged from a nineteenth century mix of healers, care givers and snake oil salesmen. Good science and disciplined professional development gave medicine and nursing the advantage that put them out in front of homeopathic medicine, chiropractors, faith healers and other health providers of various levels of merit. Nursing, hospitals, and medicine emerged together and fostered the subsequent evolution of nursing homes.

The Twentieth Century

Chapter Three presents information about social programs that evolved or were proposed in the early part of the twentieth century, prior to the enactment of Social Security in 1935. Early in the century there was much admiration for the broad social programs common to some European countries, especially Germany. World War I changed that, bringing a cynicism and distaste for European and, particularly, German policies and institutions. That said, domestic politics were the prime reason for the very limited growth of economic security for older citizens and health services in general during this era.

Meanwhile, public scrutiny of almshouses and county homes had brought them into considerable disrepute. Often they were ignored even in the towns and cities that housed them. Homes for the aged and boarding homes that provided nursing services began to be more common.

By 1930, the movement in support of old age assistance had matured to the point that many states had such programs, although their benefits often were limited. In Massachusetts, for instance, the age of eligibility for men was 70 years. In many states benefits were offered on a county by county basis. County funds sometimes provided the sole benefit or they might be matched by the state. Nowhere near as many people were covered by these meager benefits as would later be protected by the more generous Social Security programs. One important aspect of individual states' old age assistance programs is that they opened peoples' minds to the concept of public programs providing a cash benefit for elders.

Social Security is Passed

Chapter Four describes the evolution of Social Security and other programs which influenced nursing homes from the early 1930s to the 1950s. During the Great Depression, Senator Huey Long of Louisiana and Dr. Francis Townsend of California advocated similar plans for the distribution of a cash benefit to the elderly. Senator Long's "Share Our

Wealth Society" did not scare his Congressional colleagues quite so much as the "Townsend Movement" but both programs had supporters, could cost vast sums of money, and were in the forefront of national political discussion.

Rather than incorporate elements of these proposals into his own plans, President Roosevelt appointed the Committee on Economic Security to formulate an alternative scheme. The resulting plan was included in the administration's proposal for an economic security program. The old age assistance programs of the states, together with the Long and Townsend movements, had prepared the Congress and the country for such a program. The Social Security program that was enacted has matured into the system we know today.

In its initial enactment, Social Security did two important things for nursing homes. It excluded from benefits inmates of public facilities, and it distributed substantial sums to large numbers of older citizens. Beneficiaries could use the money to pay for residential care. These steps encouraged the rapid development of board and care homes and nursing homes, and sounded the death knell for almshouses and similar public institutions.

Hill-Burton and Loan Guarantees for Nursing Homes

The Roosevelt administration also tried to extend public funding for health services. It failed to find

support for a national health plan and was unable to find sufficient legislative support for its proposal for an extensive public hospital system. Eventually, it settled for partial government support for the construction and renovation of private, nonprofit hospitals. As the country prospered and medicine continued to grow, the need for all kinds of health facilities, especially hospitals, was widely felt. Government guarantees and grants under the Hill-Burton program were key elements in the development of a system of community hospitals throughout most of the United States during the next 20 years.

By 1954, the benefits of the Hill-Burton program were extended to nonprofit nursing homes, to the great dismay of the proprietary nursing home industry, which feared added competition. In 1958 legislation was passed allowing proprietary nursing homes to receive loan guarantees from the Federal Housing Administration. FHA loan guarantees became the standard financing mechanism for nursing homes, and the profit side of the industry continued to outpace the nonprofit and public sectors. For larger organizations the public sale of shares became important.

Medicaid and Medicare Enter the Picture

Chapter Five considers events that affected the passage of Kerr-Mills, Medicare, and Medicaid. Many elected officials and policy makers continued to see a need for some

sort of social health insurance. The McNamara hearings, which heard testimony from older citizens around the country, made it clear that older people feared the potentially devastating expense of medical care. Kerr-Mills was enacted into law in 1960. It was a limited and voluntary program under which states could provide a range of health services to the elderly poor, with federal reimbursement for a portion of the cost. No services were mandatory and no state was required to enter the Medical Assistance for the Aged program (MAA).

An important element of Kerr-Mills was that it recognized the condition termed "medically needy." The means test, applied before an individual could receive MAA, permitted the subtraction of medical and nursing bills from the person's assets. The idea of being medically needy extended Kerr-Mills MAA coverage to many who would not otherwise have qualified. Equally important, this concept would be carried over into Medicaid.

In 1965, President Lyndon Johnson was able to coordinate a successful effort to pass Medicare and Medicaid amendments to the Social Security Acts. Medicaid, seen then as an extension of the Kerr-Mills MAA program, was more important than Medicare for the nursing home industry. While Medicare payments for nursing home care were more generous, the implied guarantee of Medicaid, that everyone

would have coverage if financially needy, furnished a "floor on risk" for nursing home providers. Medicaid also mandated nursing home services as one of the services every state had to offer all citizens who qualified under MAA. Medicaid rapidly became the single largest payer for nursing home services in the United States.

Even as Medicaid and Medicare were being established as new programs, the Kerr-Mills MAA program was being picked up by more states. This expanded experience with Kerr-Mills and the early billings against Medicare and Medicaid soon made it clear that these programs were going to be much more costly than projected. And much of the money being paid out by Medicare and Medicaid was going into the nursing home industry.

Profit and Fraud in Nursing Homes

The huge sums made available for nursing home services by Medicare and Medicaid led to burgeoning growth in the nursing home industry. It encouraged organizations that had no previous interest in health care in general or in nursing services in particular to enter the field (an example was the Holiday Inn motel chain). These companies saw great profit opportunities if they could grow rapidly. At their request, the FHA began to guarantee bond offerings to fund the capital requirements of large, national organizations. Bonds (a consolidated debt instrument, like a mammoth

mortgage) produced substantial pools of capital for buying and building facilities much more rapidly than any standard mortgage process. Soon the most aggressive organizations abandoned the bond market and went into the stock market as public companies. The stock market sells shares representing an ownership interest in the company and can produce much more capital more rapidly than bonds.

These companies provided large numbers of additional beds (mostly in extended care facilities) very quickly and at a time when the need was great. However, there is considerable evidence that some of them used financial and other techniques that were outside regulations and fraudulent. Some companies failed and some principals were sentenced to jail terms for fraud.

Regulating Quality

In both large and small nursing home organizations quality of care remained a major problem. Successors to the McNamara subcommittee continued to hold hearings on health care and long term care for the elderly. Such hearings revealed devastating fires, widespread warehousing of disabled patients, and various frauds committed by nursing home operators, pharmacists, doctors and others.

Finally, in response to many calls for reform, the Committee on Nursing Home Regulation was formed. This group of 20 national experts studied the problems and made

recommendations, often similar to those put forth in earlier hearings and other forums.

The committee's work was the basis for the Institute of Medicine report, Improving Care In Nursing Homes, which gave rise to the "Nursing Home Reform Act of 1987" ('87 OBRA). This landmark legislation imposed stringent regulations on the entire nursing home industry, regulations that reflected advocate requests that had been made as far back as the 1950s and even earlier. While the implementation of '87 OBRA has been controversial, few would argue that it has not led to a higher national standard for care in nursing homes.

This highly codified set of regulatory standards and broad reporting requirements has become the tool by which the public sector attempts to ensure that the private sector is using public dollars properly in providing services. What's more, it is clear that the vast majority of the public dollars spent on long term care today do not go to nonprofit or community organizations as was once expected, instead, the recipients of most of this funding are privately owned, profit making enterprises. In fact, most of the money probably goes to corporate organizations that own a large number of facilities in many states.

This is a very long way from neighbors taking care of neighbors, religion based homes for the aged, or the community hospital. These apparently more benign models of

care did not build the capacity needed for nursing home beds. National chain organizations and the smaller, local, proprietary nursing home companies have done much more to increase capacity and have done so with a substantial boost from public funds and various public policy decisions over many decades.

Why Are Most Nursing Homes Privately Owned ?

From the early days of the Colonial era there has been a sense of public responsibility for someone who is poor, old and sick. What the nineteenth century came to know as "outdoor relief" was the initial community response to the needs of such people. When this public assistance meant a community sharing food and fuel with a destitute neighbor or taking the person into a private home, there was a distinctly humane element to it. However, culturally, there was not a sense that the conditions that led to such destitution needed to be changed (Friedlander, 1955; Lidz et al, 1992; Moroney & Kurtz, 1975).

Concern about the efficiency, or cost, of outdoor relief led to increasing use of "indoor relief," which quickly came to mean the almshouse. In his 1821 report, Josiah Quincy outlined the desirability of the almshouse both for encouraging good habits and for economic efficiency. He recommended agricultural pursuits so the inmates might contribute to their own keep (Board of State Charities, 1864). Disagreement about how to run almshouses

went on for many years, however, always with a concern for expense. Other facilities were developed for specific populations, such as children, the blind, and the deaf. But the poor, old and sick person still was sent to the almshouse. The dreadful conditions and high costs of almshouses were continual subjects of public concern (Lidz, et al, 1992; Board of State Charities, 1865).

Even though medicine and nursing developed rapidly in the second half of the nineteenth century, no medical services were usually available in the almshouse, despite the large number of residents and their frequently fragile health. In Massachusetts, for instance, more than 10,000 people resided in such facilities around 1860 (Dunlop, 1979; Lidz et al, 1992; Moroney and Kurtz, 1975; United States Census, 1860).

By the late nineteenth century, a shift seems to have occurred in the way that the public viewed almshouses. Very low quality of care, overcrowding, and the possible spread of disease became central concerns. Massachusetts found almost half of its almshouses to be of questionable quality. Furthermore, these facilities had become even more custodial, less rehabilitative and generally more deteriorated over time (Board of State Charities, 1865; Board of State Charities, 1875; State Board of Lunacy and Charity, 1894).

While almshouses continued to fail, some of the private charitable institutions that had sprung up to care for the sick prospered. In particular, the acute care hospital, initially a place for the poor to die, emerged in the twentieth century as a center for scientific research and the practice of medicine and nursing. The services of these mostly private, charitable institutions were sought by the middle class and the wealthy as the curative abilities of modern medical care were widely recognized (Vogel, 1979; Starr, 1982).

Although almshouses continued to exist well into the twentieth century, the Charitable Organization Societies and the Progressive era may have precipitated their extinction. The Charitable Organization Societies brought together middle class industrialists, businessmen, and religious and political leaders to visit the unfortunate and poor in public institutions. Such visits were expected to help the poor better understand society, be more responsible, and pull themselves together to leave the institution and take care of themselves. Ironically, it was these community leaders who often learned a lesson. They frequently discovered that the inmates had fallen on hard times not through weakness and sloth as expected, but as a by-product of an industrially organized society (Friedlander, 1955).

The larger society came to understand that supporting the poor and elderly in the community by means of cash

benefits would be more humane and less costly. The old religious idea that some sort of predestination caused adversity was abandoned by society (Haber & Gratton, 1994).

Almshouses and poorhouses began to try to reorganize. They changed their names. They assumed names like the "County Home" to replicate the movement toward privately operated homes for the aged. Meanwhile, in some states the almshouse system had become so ridden with bureaucracy and politics that even facilities with no inmates were funded in order to provide income and other benefits to officials and employees of these facilities (Stewart, 1925).

A 1925 Labor Department study showed that homes for the aged were growing in number. They offered medical, nursing and residential services, a mix first seen in the almshouse. Some were run by charitable organizations and some were proprietary but the vast majority were private. This reflected a distaste for publicly operated facilities such as the squalid almshouses (Bureau of Labor Statistics, 1929; Haber & Gratton, 1994).

Some almshouses lingered on for another decade or so and some county homes still exist. However, the desirability of a large system of publicly operated facilities for the poor which offered residential, medical and nursing services had been denied by society. The almshouse was recalled whenever some publicly operated residential or health care facility was proposed.

Occasionally the recollection of the almshouse would be publicly spoken, more often a political culture reflecting the deep distrust the almshouse had engendered would lead to the rejection of any similar institution.

It was this attitude that led to the decision not to fund inmates of public facilities through Old Age Assistance under the Social Security Acts of 1935. In the mid 1940s President Roosevelt was unable to get legislation passed to build a federal hospital system. In a 1954 hearing on funding for nursing home construction, one witness recalled the horror of the poorhouse as a reason for the government to support the construction of private nursing facilities (U.S. House, Siegal, 1954). As late as 1963, Ollie Randall, a nationally known advocate and expert, went out of her way to criticize the inadequacy and danger of reverting to the use of public facilities (U.S. House, Randall, 1963).

When experts are asked today about public ownership and operation of nursing homes, their replies quickly build to a consensus. Laurence Branch of Duke University said, "It is my opinion that government does not have a good track record for the efficient and effective administration of facilities. They tend to get too large and too impersonal" (Branch, personal communication, 1997). Jack Hilton, owner/administrator of Cardigan Nursing Home near Boston said, "They don't do that well with them. I don't think they can" (Hilton, personal communication, 1997). John

Marosy, a long term care consultant in Worcester, Massachusetts, "It is a rare city or town government that will decide to run its own nursing home" (Marosy, personal communication, 1997). Bob Morris of Brandeis and The University of Massachusetts-Boston said, "The reputations of the poor law homes were so bad, that's why vendor payments to public institutions were not permitted for several years" (Morris, personal communication, 1997). Finally, Herbert Shore said, "The founding fathers were interested in life, liberty and the pursuit of happiness; they were not interested in health, education and welfare" (Shore, personal communication 1997). The almshouse was dead and no large system of public health care facilities for the general population would be given a chance to succeed in the twentieth century.

Why Are Most Nursing Homes Organized as For-Profits ?

As Appendix A shows, in 1925 most of the homes for the aged surveyed by the Bureau of Labor Statistics were owned by charitable organizations. However, by 1957 there had been a radical turnaround in the distribution of facility ownership. Profit making organizations owned about 90 percent of the facilities surveyed by ANHA that year. And, as noted, there had also been spectacular growth. The number of facilities surveyed in the 1920s was only about six percent (1037) of those surveyed in 1957 (17,455). In the 1920s, charitable organizations were about 60 percent of

the 1,037 facilities surveyed. In 1957 they made up just eight percent of the facilities counted. Charitable organizations had not expanded anywhere near as rapidly as did for-profits. By 1957, the nursing home industry had grown to almost 400,000 beds.

Why had the for-profit segment of the nursing home industry grown so much more rapidly than the charitable and public sectors? As ANHA's 1957 figures suggest, new proprietary bed capacity and new proprietary facility strength outstripped the charitable and public sectors. An examination of policy over time reveals that the private, for-profit nursing home could attract the capital necessary for expansion, construction, and eventually, the development of large, nationwide chains.

Of course, to be able to attract capital there had to be a market for nursing homes. This study has described the development of two components necessary for such a market: purchasing power, and demand for services.

The movements for economic and health security for the aged produced a number of government policies that gave individual elderly citizens the funds to make choices. Prior to these movements, the choices a disabled older person had were dependent on one's own financial resources, dependent on one's own family, or the almshouse.

The old age assistance movement succeeded in most states by 1930. Indirectly, one of the principle

beneficiaries of Old Age Assistance were the boarding houses and their owners, some of whom were nurses who also provided care services (Linford, 1949). The Social Security Acts of 1935, followed by a series of amendments aided not only older people but nursing home operations. In Massachusetts the state old age assistance program and Social Security provided the stimulus for the rapid growth of boarding houses which, by the early 1940s, were licensed to provide nursing services as well as room and board (van Wagenen, 1943). Finally, Medicare and Medicaid provided an availability of funds for nursing home services that was unprecedented in the United States, thus fostering an aggressive nationwide industry, intent on profiting by this powerful revenue stream (Business Week, 1966).

The second component needed to create a market for nursing homes was a need for the service. The nursing home appears to be a modern American invention. Several elements may have contributed to the attractiveness of the nursing home to aging and disabled people. The development and maturing of medicine and nursing as professions in the nineteenth and twentieth centuries, along with major changes in the hospital developed a perception of institutional efficacy. There is some relationship between the idea of going to an institution to receive treatment from trained professionals to be cured of an acute disorder, and going to an institution run by trained professionals for continuing

assistance with chronic disability. Although this relationship is not widely discussed, it may be intuited from the patterns of growth and development of the hospital and nursing home industry and from views expressed at the time Medicare and Medicaid were being formed (Stevens and Stevens, 1974; Derthick, 1979).

The uniquely American quality of nursing homes may be related to United States society as it developed in the twentieth century. As John Knowles of Massachusetts General Hospital astutely observed, the social milieu of the United States changed after World War II. Not only was the society highly industrial and highly mobile, it had also become increasingly common for both adults of a nuclear family to work outside the household. As a result, there was not anyone left to look after a disabled family member. As these trends continued, Dr. Knowles saw an increasing need for nursing homes in the future (U.S. Senate, Knowles, 1965).

With the development of public policy to protect the economic and health security of older people, funds became available to purchase nursing services for the chronically disabled. As United States society became more mobile and fewer healthy adults remained in the household, a real need for institutional services grew rapidly.

The nursing home industry responded aggressively to this and began to use vast capital resources to expand. It

was criticized for its avarice and for decisions focused on profit rather than care (U.S. Senate, Goodman, 1961). It was stigmatized for its association with business rather than charity (U.S. Senate, Tabenhaus, 1961).

The Failure of Nonprofits

But the proprietary industry also had defenders. In various hearings, the relatively slow growth of the nonprofit sector was noted. One Massachusetts official said that nonprofits lacked the accumulated reserves to take advantage of Hill-Burton funds to expand or renovate. He expressed gratitude to the for profit sector for filling the void (U.S. Senate, Rubenstein, 1961). The President of the Minnesota Nursing Home Association, Sidney Shields, echoed this view. In his state in the 1950s, private capital provided modern nursing facilities for what were often publicly aided patients (US Senate, Shields, 1961).

Important to keep in mind is the fact that nonprofits had relied to some extent on gifts made without expectation of return. The proprietary industry promised a return on investment, and thus attracted more capital.

Even by the time Medicaid and Medicare became law, the private, for-profit sector dominated ownership of nursing homes. Because there were funds available to pay for nursing home services from individuals and from governments, because nursing home services had become widely accepted, and because United States society would clearly require more

and more such services, nursing homes attracted profit focused, private investment.

Both in Congressional testimony and in interviews with experts the same story emerged. Charitable organizations did not generally expand much; though the upper Middle West experienced exceptions. These exceptions demonstrate that rapid expansion of nonprofits can happen and that the dominance of the for-profit sector of the nursing home industry was not inevitable (see Appendix B). However, most nonprofit organizations providing nursing home care did not have missions that encouraged expansion, they did not have the capital needed for expansion, and they had decision processes that were too slow to make rapid expansion likely. Many nonprofits were established by charitable societies to serve a particular ethnic, religious or cultural group. They may have viewed any risk, however small, of losing the services they had as not worth taking.

In contrast, for-profit organizations had capital available, saw expansion as a tool to attract more capital, and saw that the efficiencies of scale realized by expansion would enhance profitability for their private owners or public shareholders. Although views were expressed in different ways, neither government officials, academic researchers nor currently active experts disagreed about these points.

The Weisbrod Three Sector Model

In The Nonprofit Economy, Burton Weisbrod said the main strength of the proprietary sector was "its efficiency in meeting demands at minimum cost" (Weisbrod, 1988, p.18). This may seem a dubious virtue where human health and well being are at stake. However, the distrust which caused government to be dismissed as a provider undercut the primary reason to seek government health services while the nonprofit community was never able to meet demand.

Two important implications of Weisbrod's model were contradicted in the case of nursing homes. The idea that consumers who could not pay for a good or a service themselves would not interest the private sector was negated by government policy. First, old age assistance by the states and then by Social Security gave money to people who would not otherwise have had it. Then government became a payer for those who did not have funds to purchase services themselves. The interest of the private market was attracted by the use of government funds.

Weisbrod's other implication is that when consumers cannot tell a high quality service from a low quality service, they will get only low quality service from the proprietary sector. Although public concern for quality frequently has been expressed over the years, government regulation has become a proxy for the knowledgeable consumer.

In the public eye, government has failed in the operation of health and residential services for the aged. However, its role as a payer and regulator has been accepted. Since the nonprofit sector has failed to meet demand, the for-profit sector, funded and regulated by the public sector has emerged as the dominant sector in nursing home services.

Despite its apparent failure in nursing home services, Weisbrod's model may remain useful when related to other sorts of goods and services. In nursing home services the three sectors interacted in ways the model did not predict.

Each of the sectors may have additional characteristics which are as important as those Weisbrod describes. For instance, it may be that government has broad access to funds through taxation, but it must also be extraordinarily careful in how those funds are spent or meet broad public criticism. The public sector may be a provider of health care as a social need, but when a city or state sets up a hospital or nursing home, it may be expected to treat all persons equally. These combined requirements for fiscal prudence (and efficiency as Josiah Quincy and others have noted) together with an egalitarian ethic may explain why some public health care facilities end up over their intended census of patients, and below the quality standard. Further speculation here is not needed. However, the

Weisbrod model makes some sense and would benefit by further development.

Implications for the Future Care of the Aged

In 1991 the General Accounting Office summarized the available research on growth in long term care services from 1991 to 2060 (GAO, 1991). It forecast that as the huge "baby boomer" generation (those born between 1946 and 1964) ages in the early twenty-first century, it will place great demands on long term care systems. Both nursing homes and paid home care services were expected to increase in number and expense, and the scale of this growth will be unprecedented.

Until 1980, the home care industry was dominated by nonprofit providers (Ellenbecker, 1995). Beginning in that year, however, as part of the Omnibus Budget Reconciliation Act, for-profit providers of home care services could be reimbursed under Medicaid and Medicare. This 1980 law created a multi-sector environment in home care similar to that in the nursing home industry. Both for-profits and nonprofits could now be reimbursed for services under the same rules.

Since many observers still are convinced that nonprofits provide a better service, it now might be asked whether restrictions should be placed on the future development of long term care services by profit making organizations (Ellenbecker, 1995). The lessons from the

development of the nursing home industry in the twentieth century seem clear. While quality problems and financial fraud occur in nonprofit facilities as well as in for-profits, their frequency and extent appear more limited in nonprofits. However, studies have not achieved a consensus on whether nonprofits provide a generally higher level of quality (Ellenbecker, 1995; Arling, Nordquist, Capitman, 1987; Munroe, 1990).

The argument for allowing profit making organizations to participate in the future expansion of long term care services is their ability to attract capital for rapid expansion. However, because of the tendency of such organizations sometimes to attract people who cheat on quality and are dishonest about financial matters, extensive regulatory safeguards must be maintained. Under such an arrangement, it would seem that the public's hope for an adequate and reliable system of services can be met.

CHAPTER 7

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APPENDIX A

**THE DEVELOPMENT OF NURSING HOME BEDS AND FACILITIES
DATA FOR THE UNITED STATES
FROM VARIOUS AND NOT ENTIRELY COMPATABLE SOURCES**

YEAR	BEDS			HOMES			
	PUBLIC	FORPROF	NONPROF	PUBLIC	FORPROF	NONPROF	
1925				55	360	622	A
1954				6539	ALL	TOLD	B
1954	260000	ALL	TOLD	9000	ALL	TOLD	C
1957	49846	263471	78986	496	15530	1429	D
1961				9582	ALL	TOLD	B
1961	421800	ALL	TOLD	11100	ALL	TOLD	C
1961	600000	ALL	TOLD	23000	ALL	TOLD	J
1965				11981	ALL	TOLD	B
1966				13151	ALL	TOLD	B
1968				12912	ALL	TOLD	B
1969				13047	ALL	TOLD	B
1970	861325	ALL	TOLD	13699	ALL	TOLD	B
1973	1,277M	ALL	TOLD	1269	16338	3722	E
1977	SEE NP	926100	457600	SEE NP	13600	4700	F
1978	1.309M	ALL	TOLD	14264	ALL	TOLD	G
1979	1.335M	ALL	TOLD	14482	ALL	TOLD	G
1980	1.362M	ALL	TOLD	14592	ALL	TOLD	G
1980	126907	1.072M	338188	936	18669	3460	H
1981	1.394M	ALL	TOLD	14710	ALL	TOLD	G
1982	1.423M	ALL	TOLD	14802	ALL	TOLD	G
1983	1.450M	ALL	TOLD	14930	ALL	TOLD	G
1984	1.470M	ALL	TOLD	14919	ALL	TOLD	G
1985	1.496M	ALL	TOLD	15136	ALL	TOLD	G
1986	1.528M	ALL	TOLD	15304	ALL	TOLD	G
1987	1.574	ALL	TOLD	15825	ALL	TOLD	D
1988	1.601M	ALL	TOLD	16010	ALL	TOLD	G
1989	1.626	ALL	TOLD	16212	ALL	TOLD	G
1990	1.662M	ALL	TOLD	16344	ALL	TOLD	G
1991	1.687M	ALL	TOLD	16487	ALL	TOLD	G

YEAR	BEDS			HOMES			
	PUBLIC	FORPROF	NONPROF	PUBLIC	FORPROF	NONPROF	
1992	1.715	ALL	TOLD	16751	ALL	TOLD	G
1994	1.713	ALL	TOLD	1084	10683	4194	I

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The reader is likely to find a number of weaknesses in this presentation of the data on nursing home development in the United States. For instance, the frequent failure of aggregated information to reflect ownership type is troubling, the differences in methodology mean that many of these figures are not entirely comparable to one another, and there are long periods for which no national figure is presented. There are data collected and published by HEW which present more detailed information on an individual facility basis, however, aggregation of that data would be a larger task than the conduct of this entire study.

Two publications of the early 1970s highlighted the difficulty of doing a specific count of nursing homes. The American Nursing Home Association published Nursing Home, 1970-1971 a fact book on nursing homes. In its introduction, ANHA explained that counting facilities was difficult because facility definitions and methodologies differed from state to state.

The House Committee on Government Operations published Saving Lives in Nursing Homes, a report on its hearings on such fires plus staff and administration data. The report stated that there was no reliable count of facilities (U.S. House, Report 92-1321, p.6, 1972). It recommended that the Office of Management and Budget devise a statistically correct collection of information on elder housing of all

sorts, including nursing homes and room and board facilities (U.S. House, Report 92-1321, p. 10, 1972).

Both of these publications described the development of nursing homes as seen here. The work done over the years to monitor the nature and size of the nursing home industry in this country has been markedly limited and inconsistent. Data exist to improve the picture presented here, but have not been aggregated into a useful form at this time.

APPENDIX B

ANOMALIES OF THE UPPER MIDDLE WEST

A comparison of nursing home ownership state by state reveals that for-profit homes are not dominant everywhere. In some states such dominance hardly exists or is reversed. According to the data collected by Health Data Associates for 1994, the upper Middle West contains a number of states that are anomalous in this regard.

In Wisconsin there were 203 proprietary homes, but there were also 143 voluntary, or nonprofit facilities. More than 40 percent of the private facilities are nonprofits; the for-profits make up less than 50 percent of the 412 total facilities.

In Minnesota the 236 nonprofits make up more than half of the 454 nursing homes and the for-profit count of 147 is only about 60 percent of the nonprofit count. The Dakotas show similar patterns, but with very few facilities. North Dakota had 9 for-profits, 74 nonprofits and 2 government facilities. South Dakota had 37 for-profits and 72 nonprofits and 5 government facilities.

In hopes of learning something about these unusual patterns of ownership, experts in Wisconsin and Minnesota were asked about their states and why they have such strong nonprofit sectors. Tom Ramsey, a lobbyist for the Wisconsin Association of Homes and Services for the Aging, said, " We don't have much to point to other than the Scandinavian

ethic of the people who live here. As a fellow of Irish descent, I'm not sure I understand it" (Ramsey, personal communication, 1997).

Mike Berry, Administrator of St. Ann's Home for the Elderly agreed to some extent. He said, "There is a Midwestern ethic about taking care of your own" (Berry, personal communication, 1997). However, he went on to say that in 1974, when Pat Lucey was governor about 6000 beds in state mental facilities changed status and became nonprofits in some way.

Jeff Bostic of the Minnesota health and Housing Alliance talked about the long tradition of nonprofit facilities in Minnesota and the well established church groups. In a situation that is quite different from many other states he said that the Good Samaritan Society (of the Lutheran Church) has a larger chain of nursing homes in Wisconsin than does the national giant, Beverly Enterprises, Inc. This picture is consistent in some ways with the idea of a strong social tradition of caring for ones own, but it was surprising to learn that most of the county facilities no longer existed because they had been sold to private organizations. Nonprofits like the Good Samaritans were apparently prominent buyers, the Good Samaritans also purchased some facilities from Beverly Enterprises (Bostic, 1997).

Bostic's colleague at Minnesota Health and Housing, Darrel Schreve made roughly the same initial remark that others had made when asked about ownership mix in Minnesota, "The state has a strong social welfare component in its culture..." he said (Shreve, personal communication, 1997). However, he went on to discuss the Minnesota Rate Equalization Statute of 1976. Under this law, a nursing home may not charge a resident any more than the state Medicaid rate. Under federal law a nursing home generally may not charge a resident less than the Medicaid rate.

The limited analysis of ownership patterns in Wisconsin and Minnesota is consistent with some general explanations used in the larger study. Underlying political cultures are important elements in the way that nursing home and other services develop. The emphasis on caring for one's own, having integrated social service systems, or having a "Scandinavian" ethic all are ways of describing political cultures or ways of thinking common to these states.

Public policy may reflect that social view and powerfully affect services development. For Wisconsin in the mid-1970s, the massive conversion of public mental health facilities to nonprofit facilities is consistent with the political culture being described and stimulated a rapid increase in nonprofit facilities. The Minnesota statute which effectively sets the Medicaid rate as the only rate in Minnesota would immediately discourage for-profit providers.

The aggressive acquisition of facilities by large nonprofits like the Good Samaritans would accentuate the effect of this statute.

The same sort of analysis which has led to the conclusion that profits grew far more rapidly than nonprofits nationally, accepts the dominance of nonprofits in these states. The national political culture, public policy and business opportunities favored the for-profits nationally. In the upper Middle West, it seems that nonprofits were similarly favored.

The experience in the upper Middle West shows that dominance of the nursing home industry by for-profit organizations is not inevitable. Under some circumstances nonprofits seek to expand their services rapidly. In some instances they are also successful in raising the capital needed to substantially expand their operations. Further research is needed to understand the exceptional circumstances in which nonprofit ownership of nursing homes remains strong and is aggressive.

APPENDIX B
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