

**Long-Term Care for the Disabled Elderly:
Current Policy, Emerging Trends and Implications for the 21st Century**

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WORKFORCE ISSUES

Financing mechanisms and delivery systems are essential but not sufficient for sound long-term care policy. The most important and overlooked dimension of this policy issue is the adequacy and availability of a trained workforce to deliver the care. Today's professional and paraprofessional workforce is woefully unprepared to address the long-term care needs of an aging society, and this problem is likely to worsen as the baby boomers age in the first half of the next century.

While physicians are not primarily responsible for the provision of long-term care, their involvement is essential for ensuring the linkages between the primary, acute and long-term care delivery systems. Furthermore, in order to treat chronically disabled elderly persons with comorbidities and functional limitations, they should be aware of and knowledgeable about the range of long-term care resources that are available in the community to complement their patients' medical care needs. Finally, they should recognize and be sensitive to the needs of family members who are often the primary caregivers and involved in the decisionmaking for the elderly parent.

Unfortunately, most physicians in the United States have no training in long-term care and do not understand the interrelationships between their patients' health conditions and their physical, social and psychological needs. Very few medical students are drawn to geriatric medicine, a specialization which trains health professionals to understand the unique and diverse needs of elderly patients. Some are exposed to long-term care when their patients are discharged to home health agencies, but most physicians simply sign off on care plans rather than being involved in the provision and monitoring of care. Medical directors of nursing homes generally have formal or on-the-job training in geriatrics, but relatively few physicians choose this profession.

Only 8,800 of the 684,000 American physicians (1.2 percent) in the United States today are certified in geriatric medicine (Larson, 1998). Only 14 of the 126 medical schools offered courses in geriatric medicine in 1992, and fewer than three percent of recent medical school graduates have taken electives in geriatrics. In 1992, a survey of primary care residencies found that long-term care experience in geriatrics was required in 86 percent of family practice residency programs compared with 25 percent of internal medicine programs (Counsell et al., 1994). Most geriatric curricula in the programs surveyed were taught in nursing homes with less emphasis given to rehabilitation and home care as well as coordination of care between acute and chronic care settings.

Of the 98,000 medical residency and fellowship positions supported by Medicare in 1998, only 324 were in geriatric medicine or geriatric psychiatry. Furthermore, more than 20

percent of slots in the top 16 geriatric fellowship programs went unfilled from 1991 to 1994 for lack of qualified applicants (Besdine, 1994). Currently there are only about 500 geriatric specialists in American medical schools. This faculty shortage is exacerbated by the fact that current academic geriatricians spend most of their time treating patients. Clinical care, not teaching, brings in revenues.

The shortage of paraprofessional workers—certified nursing aides in nursing homes and home care aides—is currently a crisis for long-term care providers in the United States. Ironically, much of this crisis can be attributed to the booming local economies, where employment rates are low and where nursing homes and home care agencies are competing with fast food restaurants that offer higher wages and better benefits. The paraprofessional worker is among the lowest compensated in the service sector ("Who makes what," 1998). Unattractive job features include low wages and benefits, lack of career advancement, high potential for injury and exposure to much emotional stress. According to the 1996 National Occupational Employment and Wage Data (BLS, 1997), the median hourly wage for nursing assistants was \$7.46, \$7.51 for home health aides and \$6.48 for personal and home care aides. Furthermore, Crown et al. (1995) reported that 28.5 percent of nursing home aides had no health insurance coverage; the comparable estimate for home care aides was 38.9 percent. Only 35.7 percent of nursing home aides and 24.6 percent of home care aides had employer-sponsored pension plans.

Despite federal requirements that nursing home and home care aides working in Medicare/Medicaid certified organizations receive a minimum of 75 hours of training (Simpkins, 1997; IOM, 1996), the content and quality of paraprofessional training vary widely across states (Feldman, 1994). Nursing aides rank third in the incidence of injuries and illness that involved loss of work days (OSHA, 1998); the injury incidence rate per 100 full-time workers in 1996 was 16.2 percent for nursing home aides and 8.6 percent for home health care workers. The most common problems were back injuries resulting from inappropriate lifting and transferring of patients. There is also evidence of worker abuse in both institutional and home settings, often inflicted by cognitively impaired clients with severe behavior problems. Racial tensions between white care recipients and nonwhite aides may exacerbate the situation.

Because of problematic working conditions (lack of respect, autonomy and job mobility), heavy workloads, lack of extrinsic rewards and the availability of other job opportunities, high burnout rates lead to annual turnover rates that far exceed other types of employees (Atchley, 1996; Banaszak-Holl & Hines, 1996). High turnover has significant financial and psychological costs for providers, as well as increasing the workload for remaining staff and lowering staff morale. Several large scale studies have confirmed the intuitive notion that the initiatives most likely to have a positive effect on recruitment and retention include those that: 1) provide competitive salaries; 2) create opportunities for career advancement; 3) explicitly recognize aides' contributions; 4) involve aides in care planning; and 5) foster a good working relationship with nursing staff (Feldman, 1994; Banaszak-Holl & Hines, 1996). Research findings suggest that while wages are important, they do not reflect the driving force in recruiting and retaining workers. Many caregivers derive immense satisfaction from the caring and nurturing functions their jobs require; most respond well to recognition awards and career opportunities within the long-term care system. Salary and benefit considerations, however, are more likely to be major factors in this strong economy.

Several key points that should be drawn from this discussion include:

- A well-trained and qualified workforce for the 21st century is the weakest leg of the three-legged long-term care stool.
- Despite the demographic imperative of an aging America, relatively few physicians or other health professionals are trained in geriatrics; there are little financial or cultural incentives to pursue formal careers or to obtain extensive training in how to care for older adults with chronic illness and disabilities.
- The availability and retention of well-trained paraprofessional frontline long-term care workers is a serious issue for long-term care policy. The shortage of workers and high turnover rates due to low wages, poor or nonexistent benefits and the lack of recognition and career ladders has been exacerbated by our strong economy in which competition from other service industries (e.g., fast food chains) is fierce.

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