What Will Long-Term Care Be Like in 2040?

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Many innovative long-term care models can now be found in nursing homes, assisted living, and community home care settings. Key forces that will shape the future include the aging of the baby-boomer generation, personal choice, concerns about quality, new technologies, dementia research, payment issues, financial pressures, and workforce needs.

Long-term care is a broad term that refers to medical and social services designed to meet the needs of people, most often elderly individuals, whose ability to perform daily activities has been impaired by chronic health problems [1]. As recently as a generation ago, long-term care in the United States consisted largely of nursing home care and family care. Hospice, assisted living, and community alternative programs did not exist, and Medicare did not pay for home health care. People who sought cutting-edge models of geriatric care were directed to Europe, particularly Scandinavia.

Much has changed in the intervening years. Now the United States is a center of experimentation and innovation in long-term care, and Europeans look here for new ideas—especially for models of public-private synergy. Therefore, as we consider options for the future of long-term care, it is helpful to bear in mind that the forces that will shape this field will likely be national rather than international.

Forces Shaping the Future of Long-Term Care

Numerous forces will influence the evolution of long-term care in the coming decades. These include the aging of the baby-boomer generation, an emphasis on personal choice, an emphasis on quality of care, technological innovation, the search for new treatments for dementia, payment issues, financial pressures, an emphasis on home care rather than residential care, and workforce needs (see Table 1).

Clearly, the aging of the baby boomers will be a central theme, not just because there will be proportionately more older adults, but because the characteristic feature of this generation has been to transform institutions as they move through the life cycle. Because of their individualism, members of this generation will continue to drive the move toward personal choice and person-centered care, diversity of care options, and an emphasis on home-based care. Many baby boomers are currently caring for their aging parents, and the opinions they develop based on those experiences will shape and spur their role as advocates for innovation and change, in addition to positioning them to be better informed about long-term care.

Measurement and disclosure of the quality of care has already become standard in some areas of long-term care; for instance, the federal government's Nursing Home Compare Web site posts quality ratings for all nursing homes [2]. [Editor's note: The Nursing Home Compare Web site is discussed in the sidebar by DePorter on pages 338–339.] This type of publicly available information makes issues related to quality more evident to consumers and will increasingly drive their decisions regarding long-term care.

Scientific progress will be another driving factor. Technological innovation will continue, and robotic care providers, smart homes, and a variety of electronic monitoring and decision-making systems are likely to assume an increasing role in the provision of care. A significant unknown is whether and to what extent new medical treatments for dementia will be developed; a treatment that markedly slows the progress of the disease could change the entire profile of the illness, in which case nursing home growth might slow down and community-based care could become much more the norm, even at the end of life [3].

Finally, payment systems and pressures to contain public costs will increase scrutiny regarding all care models, further intensifying the debate over the cost effectiveness of home-based care compared with residential care [4, 5]. Those pressures are likely to lead to the development of new or altered models of care. Workforce needs and shortages will also play a key role in policy development.

New Models of Residential Long-Term Care

Today, there are primarily 3 types of settings for residential long-term care: nursing homes, assisted living, and continuing care retirement communities. Each will evolve further in the future.

Nursing homes. The most notable change in long-term care has been the development of alternatives to traditional nursing home care. The institutional nature of nursing homes has given way to a culture change movement, which aims to improve the quality of life of nursing home residents through

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TABLE 1.
Key Forces Shaping the Future of Long-Term Care for Older Adults in the United States

Current trends	Possible implications
Aging of baby boomers	Experimentation and diversity in forms of care will increase.
Emphasis on personal choice and person-centered care	Choice in all aspects of care will increase.
Emphasis on quality improvement	Publicly available quality ratings will increasingly drive quality improvement.
Technological innovation	Robots, smart homes, electronic health monitoring and communication, and other innovations will reduce dependency on human caregivers.
Search for new treatments for dementia	Development of new treatments for dementia will be a major determinant of the need for and format of long-term care.
Funding of care by private payment and Medicaid	Dependency on private payment and Medicaid is likely to continue; hopes for long-term care insurance have not been realized.
Financial pressure to contain public costs	There will be increased accountability among both home-based and long-term care services, as well as increased copayments and deductibles.
Trend toward home care rather than institutional care	The trend toward home-based service models will continue and increase for persons who do not have extensive care needs or dementia.
Workforce needs and shortages	Immigration laws may change to allow an influx of foreign workers to serve as nursing assistants and home health care aides.

person-centered care structures and processes [6]. Not all nursing homes have undertaken broad culture change, but virtually all providers are aware of the national movement, and many have embraced practices consistent with culture change (eg, evidence-based individualized bathing and mouth care practices) [7, 8]. Examples of culture change models include the Wellspring Model, the Eden Alternative, and more recently, Green House homes [9].

Green House homes provide care for groups of 6–12 residents, each of whom has a private room and bathroom; residents' rooms open onto a central living area adjacent to an open kitchen (see Figure 1). A consistent, self-directed team of staff members is responsible for all care, including preparation of meals. As of October 2013, more than 150 Green House homes were operating on 34 campuses in 24 states, and more than 150 homes were in development in an additional 8 states; one is scheduled to open in Bostic, North Carolina, in 2016 (oral communication from Susan Frazier, director of the Green House Project; October 2013). Future growth of this model may depend on whether evidence supports the belief that Green House homes provide a better quality of care.

FIGURE 1.
In contrast to the dining environment of a traditional nursing home, the kitchen and eating area in a Green House home are designed to resemble those of a private home.

Assisted living. The second key evolution in residential long-term care is the development of assisted living as a home- and community-based service. Assisted living settings grew by 97% in the 1990s [10], as older adults who required supportive care but did not need nursing care sought personalized and less expensive housing options. All such settings provide a room, at least 2 meals a day, and unscheduled oversight 24 hours a day; however, service provision and costs vary tremendously among residences. Important considerations for the future are whether affordable assisted living care will continue to grow and whether Medicaid will pay for it; Medicaid currently provides support for only 19% of the residents of assisted living, given state limitations to support this type of care [11]. Also, there may be an increasing push for the measurement and disclosure of information about the quality of assisted living, as has occurred for nursing homes [12].

Continuing care retirement communities. In addition to nursing homes and assisted living, continuing care retirement communities provide another option for long-term care. These communities and similar care models offer combinations of independent living, assisted living, and/or nursing home care on a single campus. The trend toward combined housing models is likely to continue, but the stigma that accompanies a transition between levels of care should be recognized [13]. Because increasing care needs are highly visible in such a social setting, much needs to be done to counter this stigma.

The differences between the various options for residential long-term care, in terms of who lives there and the services provided, may become more distinct over the next 25 years. Already, assisted living has demonstrated its ability to care for residents with dementia who do not have ongoing medical needs [14, 15], and many assisted living residences provide nursing services [16]. Although assisted living residents can contract for rehabilitation services when necessary, nursing homes will likely remain the main provider of residential acute and rehabilitative care, and assisted living

will become more recognized for providing long-term supportive care.

New Models of Home-Based Long-Term Care

As a result of many of the forces outlined in Table 1, home- and community-based care has assumed a markedly more prominent role in relation to residential models of care.

Caregiver support programs. One of the most important trends affecting home- and community-based long-term care is the growing recognition of the burden borne by family caregivers and of the needs of these caregivers, who have long been the backbone of long-term care. The unpaid care and support provided by family and friends in order for aging relatives to remain at home was valued at $450 billion in 2009, an amount greater than total Medicaid spending [17]. However, the provision of that care can have adverse consequences for caregivers' well-being, particularly for those caring for people with dementia. In response, more formal support mechanisms for caregivers have been developed as payers look to avert nursing home placement. One such program in North Carolina is the Caring for Older Adults and Caregivers at Home (COACH) program at the Durham Veterans Affairs (VA) Medical Center, which provides home-based support and dementia care coordination in collaboration with the patient's primary care team and an interdisciplinary support team. The program has been well received, and its initial implementation saved the center money [18]. Over the coming decades, however, caregiver support policies will be hard-pressed to cope with demographic changes resulting in a decreasing ratio of available family caregivers to persons needing care [19]. Consequently, there will be pressure for programs to increase the supply of home health aides and home care assistants.

Community mobilization. Another trend fueling the shift away from residential care models is a grassroots mobilization of community support networks for aging in place. A 2010 AARP telephone survey found that 86% of older persons would prefer to age at home [20]. However, disability and frailty often make complete independence impossible. In response, the phrase *aging in place* is giving way to the concept of *aging in community*, in which neighbors organize to help one another.

One example is the Villages movement, in which residents of a geographic community self-organize to coordinate support services for residents who pay an annual membership fee. Currently more than 50 such villages are operating across the country, inspired by the original Beacon Hill Village, which began operation in 2002 in Boston [21]. Another model is *naturally occurring retirement communities* (NORCs)—housing complexes or neighborhoods that have accrued high concentrations of older residents. In NORCs, formal supportive service programs are instituted by community-based organizations through a mix of public and private funding [22]. In the future, community-supported models can be expected to grow dramatically, driven by need and preferences, particularly if cost effectiveness of these models can be demonstrated.

A relatively new care model that blends community mobilization with formal support is the neighborhood-based care home model. One example is the Charles House–Yorktown Eldercare Home in Chapel Hill, North Carolina, a neighborhood-based program that provides residential elder care and seeks to engage the surrounding neighborhood in mutually enriching activities (see Figure 2). Licensed since 2011 as a residence for up to 6 individuals, the Yorktown Eldercare Home employs a household staffing model and follows a holistic care philosophy. Members of the program staff work with families to shape their continued role as caregivers and to incorporate them into household life. Neighbors and community partners are also involved in life at the home, informally and through service-learning partnerships. Significant challenges that may affect the future spread of this type of socially focused model of care include pervasive ageism and generational differences in areas such as core values and perspectives on work/life balance. The growth of the aging population may exacerbate these tensions, or it may serve as a catalyst for greater mutual understanding.

Medical models for those with extensive care needs. There is great interest in strategies for providing high-quality care while reducing costs for the poorest and sickest individuals. This group includes 9 million dual-eligible people who are enrolled in both Medicare and Medicaid, whose health care needs are often complex and costly. The Program of All-Inclusive Care for the Elderly (PACE) represents a promising strategy and is growing rapidly, bolstered by evidence of participants' decreased use of acute care and need for nursing home placement [23, 24]. PACE programs aim to avert the need for nursing home admission by comprehensively addressing older adults' medical and social needs through team-based care in an adult day health care setting [25]. [Editor's note: PACE programs are described in more detail in the sidebar by Shaw on pages 344-345.] Given anticipated growth in the number of individuals who will have

FIGURE 2.
Patio gardening at Charles House–Yorktown combines exposure to outdoors and sunlight, socialization, tactile stimulation, and a sense of purpose—all in a homelike setting.

extensive care needs in coming decades, the development of additional and more varied models of multidisciplinary team care can be expected.

International Solutions

In today's global economy, international solutions for long-term care must be considered. These models could include encouraging immigration of foreign workers who can provide long-term care in the United States, or emigration of US residents to other countries to receive long-term care.

Encouraging immigration of foreign workers. Other developed countries with high proportions of elderly individuals have for years invited foreign workers to serve as nursing assistants or health care aides [26, 27]. For example, large numbers of health care workers have emigrated from Peru to Italy, from Southeast Asia to Japan, and from Eastern Europe to the Netherlands. In the United States, registered nurses from other countries (most notably the Philippines) have filled shortages in some nursing homes; however, the influx of such workers has been hampered by immigration laws and licensure requirements. As a result, foreign workers are rarely employed in nursing homes; they more often work in home care settings, where requirements tend to be less stringent [28]. Future programs that train and support workers from less developed countries could markedly improve the availability of personal care services while lowering costs [29]. However, such programs will need to address the cultural differences between caregivers and care recipients.

Outsourcing long-term care. An interesting cost-effective option would be to develop long-term care options in Latin America, where cheaper labor can provide inexpensive, high-quality personal care services. *USA Today*, in a 2007 cover story on long-term care in Mexico, reported that the average hourly fees for a home health care aide and a homemaker-companion were $19 and $17, respectively, in the United States, compared with $9 and $2–$5, respectively, in Mexico [30]. These figures suggest that going to a foreign country to receive long-term care is an option worth considering.

Until recently, the retirement industry in Mexico—the country with the largest number of expatriate Americans—had focused on "active living" communities and not on long-term care services. This approach is rapidly changing, and assisted living communities targeted at US retirees are beginning to emerge in many locations, including San Luis Potosi, Rosarito, San Miguel de Allende, and Ajijic [31].

One example of such an assisted living community is a residence in Ajijic (see Figure 3). In 2008 this for-profit, family-owned business consisted of 3 separate, contiguous homes and served 16 residents, nearly all of whom were US citizens. For fees ranging from $1,000 to $1,400 per month (depending on services needed), residents received room, board, medication oversight, and assistance with personal care. A local physician provided home visits, and 2 caregivers were working onsite at each home at all times.

In coming decades, growth of the industry, combined with pressure to save money, could lead Medicaid programs in border states such as Texas, New Mexico, Arizona, and California to consider outsourcing a significant portion of long-term care. For residents of more distant states, such as North Carolina, traveling abroad for long-term care is likely to be an option only for persons who pay privately for care and who seek an option that combines high quality of life with low cost.

FIGURE 3.
Five adjacent homes in the Lake Chapala region of Mexico provide an assisted living–like setting for a fraction of what it would cost in the United States, but also with fewer regulations. Most of the residents of this community are Americans.

Discussion

This commentary identifies some of the dominant themes in long-term care and presents some of the most promising models of care currently being tried. The exact shape of the future of long-term care is uncertain, however, and will depend on the forces identified in Table 1, plus other forces that will emerge with further societal change.

Remaining at home is a dominant theme among both older adults and planners of long-term care. However, perhaps a more defining principle in the future will be the search for residential normalcy—that is, settings that maximize both comfort and a sense of mastery [32]. Such an approach would give legitimacy to a much wider range of options, and in that context, having several different models of care would help the largest proportion of long-term care users to maximize their personal sense of residential normalcy.

Payment system change is one of many unknowns. The Community Living Assistance Services and Supports (CLASS) Act was passed by the US Congress as Title VII of the Patient Protection and Affordable Care Act of 2010, but it was then repealed in October 2011 when the US Department of Health & Human Services was unable to figure out a way to make it financially viable [33]. Will it be reinstated or reconfigured, thereby encouraging innovation? Or will public funding continue to be dominated by a desire to minimize costs? If so, will the gap widen between the care that wealthier people can buy and what poorer individuals receive?

The future of long-term care will likely be at least as untidy, heterogeneous, and rapidly changing as the present.

For persons with interest in and enthusiasm for this important component of health care, the coming decades will be an exciting time. NCMJ

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