COMMENTARY

Why Home Care Costs Too Much

Regulations often require that nurses do simple tasks like administer eyedrops.

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By Paul Osterman
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As baby boomers age into long-term care facilities, Medicaid costs will go through the roof. Americans already spend—counting both public and private money—more than $310 billion a year on long-term support services, excluding medical care, for the elderly and the disabled. Medicaid accounts for about 50% of that, according to a 2015 report from the Kaiser Commission on Medicaid and the Uninsured. Other public programs cover an additional 20%.

Yet in another decade or so these figures may look small. In 2015 around 14 million Americans needed long-term care. That number is expected to hit 22 million by 2030. There's an urgent need to find ways of providing good long-term care at a lower cost. One fix would be to deregulate important aspects of home care.

There are two million home health aides in the U.S. They spend more time with the elderly and disabled than anyone else, and their skills are essential to their clients' quality of life. Yet these aides are poorly trained, and their national median wage is only a smidgen more than $10 an hour.

The reason? State regulations—in particular, Nurse Practice Acts—require registered nurses to perform even routine home-care tasks like administering eyedrops. That duty might not require a nursing degree, but defenders of the current system say aides lack the proper training. "What if they put in the cat's eyedrops instead?" a health-care consultant asked me. In another conversation, the CEO of a managed-care insurance company wrote off home-care aides as "minimum wage people."

But aides could do more. With less regulation and better training, they could become as integral to health-care teams as doctors and nurses. That could improve the quality of care while saving buckets of money for everyone involved.

Take hospital readmissions. When elderly people leave the hospital after an acute incident, they often end up readmitted for another costly stay within 30 days. Or they're sent not home but to an expensive long-term care facility. Home-care aides can improve such transitions. A recent trial program at New York University Hospital found that when aides were trained to work with heart patients upon discharge, the patients were significantly better at maintaining their health.

Aides could act as health coaches, working on diet and exercise with people suffering from chronic conditions such as diabetes. They could facilitate communication between doctors and nurses, reporting on changes in the patient's condition. Today's rules don't explicitly bar them from these tasks, but the regulations that treat aides as mere drudge workers prevent them from expanding to fill this natural role.

Then, with improved training, aides could take on some tasks now done by nurses, such as giving patients those eyedrops or other prepackaged medicines. It's just a matter of scaling up existing curricula. A monthlong program, developed by the nonprofit Paraprofessional Health Institute, teaches aides about chronic diseases, handling clients with dementia, and performing simple medical tasks. New York state has created an "advanced aide" classification to recognize such training.

Since nurses will continue to supervise aides, there's no reason patients should fear any decline in the quality of their care. A useful comparison is Medicaid's consumer-directed version of long-term support, under which patients can hire, train and supervise their own aides. There are no scope-of-practice restrictions, and research shows patients do just as well as under the typical model.

Yet the potential cost savings are considerable. There are 2.3 million Medicaid patients receiving long-term care at home. Imagine if even half of them replaced one hourlong nurse's visit a month with a stop by a trained aide. Assuming the nurse makes $35 an hour and the aide $15, that's an immediate savings of roughly $275 million a year.

Additional savings would come from fewer visits to the emergency room due to better care of chronic conditions. The same goes for fewer admissions to nursing homes. The median cost for a year's stay in a nursing home is $90,000, while the figure for home care is less than half that, according to the AARP.

What's standing in the way of fixing these home-care regulations? Often it's simply the jostling among the health-care professions, no different than the longstanding struggle on construction sites about who can put the plug into the socket. But the people paying the bill for long-term care—state Medicaid agencies, managed-care insurance companies, and (in the end) taxpayers—ought to press lawmakers to scale back these regulations and think more broadly about what aides could do.

Mr. Osterman, a professor at the MIT Sloan School of Management, is the author of "Who Will Care for Us? Long-Term Care and the Long-Term Workforce," just out from the Russell Sage Foundation.

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