Reorganizing the Nursing Home Industry: A Proposal

DAVID SHULMAN

RUTH GALANTER

This paper proposes a reorganization of the nursing home industry with capital facilities owned by government, but with management conducted through a system of competitive contracts with the private sector. The paper explicitly demonstrates in real estate finance terms how the present system of private ownership of captial facilities inherently impedes providing a high quality of care.

The authors believe that in the proposed industry reorganization, market forces, instead of working against quality care, would be supportive of quality care in a framework that would involve generally less regulation than exists today.

Overview

This is a proposal to restructure the nursing home industry so that market forces will reinforce public policy objectives instead of impeding them, as they do at present. We propose a reorganization of the industry with capital facilities owned by government, rather than the private sector, but with management conducted through a system of competitive contracts with the private sector. This is not itself a solution to the problems of the nursing home care currently available, but it is prerequisite to solution; government ownership of capital facilities would transfer nursing home operators' financial incentives away from real estate investment and into patient care. At present, services already given must be reimbursed, regardless of the quality of those services or of pending action against the facility or operator. Consequently, abuses continue, and continue unpunished, long after they are discovered. The type of management contract we propose would require successful performance of the contract specifications in order to collect reimbursement and is thus an important handle for enforcing standards. This proposal should not be interpreted as a justification of nursing homes instead of alternative forms of care or as an argument that nursing homes can ever be truly satisfactory health care institutions.

The nursing home industry is a disaster, well documented by innumerable investigations and reports (U.S. Senate..., 1975; U.S. Department of Health, Education, and Welfare, 1975).[1] Demands for reform, reasonably enough, have accompanied the recent disclosures of abuse, inadequacy, and cheating, and proposals for reform are legion. With a few exceptions (such as a "bill of rights" for nursing home patients), the reform proposals rely heavily on increased governmental supervision, regulation, and funds: more training programs for nursing home workers, more subsidies for building, more inspections, more elaborate record-keeping requirements.[2] Even assuming passage and adequate funding of these reforms, past experience in the nursing home industry and in other regulated industries suggests that this route alone is unreliable and definitely not cost-effective.

Government created, supports, and is ultimately responsible for the maintenance of the nursing home industry. Between 1960 (prior to Medicare and Medicaid) and 1974, nursing home care expenditures grew approximately 1400 percent (U.S. Senate..., 1975: I, 21). As of 1973, the country had 16,000 nursing homes with a total of 1,200,000 beds, generating $3.9 billion of revenue (Standard and Poor's Industry Surveys, 1974). In 1974, revenue had increased to $4.3 billion, and by 1975 revenue is estimated to hit $4.7 billion (Standard and Poor's Industry Surveys, 1975). If homes offering personal care (without nursing) and domiciliary care are included, the 1974 total is 22,000 (U.S. Department of Health, Education, and Welfare, Public Health Service, 1974).

Three-quarters of the private nursing homes are operated on a for-profit basis (Standard and Poor's Industry Surveys, 1975). Although there remain a number of family-owned and managed nursing homes, most of the nursing home industry (measured in volume) is organized with the same split between ownership and management as the rest of American business. Nursing home operators can be expected to conduct themselves as "rational businesspeople." Failure to do so would lead to a foreclosure by

[1] See also New York Times (1975: 1804-1807). Of the various references listed there, see especially the October 7-10 four-part investigative series and stories beginning October 17 on the New York State Temporary Committee on Living Costs.

[2] Senator Moss, Representatives Abzug and Koch, and others have already introduced in Congress close to 50 bills dealing with nursing home reform. Some types of reforms have been instituted. In New York, for instance, the state is now required to perform quality assessment as part of its regular review.

the mortgage holder with a resulting loss of the facility. Or, at an earlier stage, a manager's failure to behave as a "rational businessperson" would lead to the owner's getting a new manager.

Nursing homes derive their basic authority to exist from state licensing requirements, administered by an agency of or delegated by state government. To be eligible for reimbursement under Medicare and/or Medicaid, nursing homes must be certified, by government, in a process separate from their regular licensing. The federal government has promulgated standards the homes must meet in order to be certified (Code of Federal Regulations [CFR], 1972; 1973); although the standards leave a lot to be desired, they are all the "law" there is.

Although the care is provided by private institutions, two-thirds of the industry's revenue comes from government, through Medicare, Medicaid, and other programs (Standard and Poor's Industry Surveys, 1975). Moreover, under the current fiscal structure, nursing home investors receive multiple subsidy: the reimbursement formulas include a percentage return on invested capital,[3] and the sheltering of income from taxation by investment in real estate means that the government foregoes taxes it would otherwise collect.[4] Both these forms of government subsidy provide government-funded income to entities which may have no interest or competence in nursing home care and no responsibility for nursing home care.

In some places, state government subsidizes construction of nursing homes and/or non-profit hospitals through medical care facilities finance agencies which provide up to 100 percent financing.[5]

Through inspection procedures, government is also ultimately responsible for maintenance of the facilities. Inspection for compliance with and enforcement of state and local building, fire, and

[3] Medicare reimburses according to a cost formula which includes depreciation, interest on debt, and a return on owner's equity of 1½ times the long-term U.S. Treasury bond interest rate as allowable costs. Medicaid reimburses on a per day capitation payment basis, with the amount of the payment determined by the state government.

[4] Real estate investment is especially attractive to people in high tax brackets, and the marketing of such investment opportunities is directed to such people. For an example of how nursing homes fit in, see Needham (1969).

[5] The New York State Medical Care Facilities Finance Agency grants 90-100 percent financing to non-profit nursing homes. (With 100 percent financing, there is *no* owner's equity involved.) In April 1975, that agency sold $62 million in revenue

other safety codes is usually done by state or local health departments, fire departments, building departments, or several of these agencies. When any of the responsible agencies conducts an inspection or review and finds a violation, it must follow specified procedures to induce change. All of these procedures take time, and the process can be turned off at any of the stages.[6] The entire process is easily abused through bribery or through the more subtle pressures that typically dilute the effectiveness of regulation (constant contact of regulators with regulatees and very little contact with those on whose behalf the regulators theoretically operate). But the problem is not only with individual inspectors; regulatory agencies frequently have official or unofficial policies in favor of negotiation rather than prosecution, and the resulting "political climate" makes termination of licensure or certification very difficult. In addition, current reimbursement structures preclude refusing to pay for services rendered during the decertification process.[7]

bonds whose proceeds were allocated to the construction of non-profit hospitals and nursing homes. A total of $14.7 million was allocated for nursing homes (New York State Medical Care Facilities Finance Agency, Hospital and Home Project Bonds, 1975 Series A, Prospectus, April 23, 1975). As a result of New York's financial troubles, this agency has been unable to sell additional bonds. However, the Illinois Health Facilities Authority, the Connecticut Health and Educational Facilities Authority, and the Philadelphia Hospitals Authority successfully sold bonds in 1975.

[6]Inspection for compliance with and enforcement of these types of standards is generally done by the state or local health departments. In addition, there are standards which may be within the purview of the local building department or the local fire department. When any of the responsible agencies conducts an inspection or review and finds a violation, it must follow specified procedures to induce change. If all proceeds normally, however, there will usually be a notice provision specifying a time period for correcting the deficiency. Then there must be a reinspection. There may be "second notice" procedures. Finally, though, there is the power of prosecution. However, prosecutors are generally not from the same agencies as the inspectors. Inspectors merely file complaints with prosecutors. Prosecutors have other things to think about besides nursing homes, and they are not always anxious to prosecute—particularly when both they and the courts view the issues as essentially civil rather than criminal. Even if they do prosecute, the case may take months to come to resolution and the fine may be quite minimal. Even when the process works completely on schedule, throughout the court proceedings the violation may remain uncorrected.

[7] Under CFR 20 405.604, 615 all services prior to decertification are reimbursed by Medicare and Medicaid (Code of Federal Regulations [CFR], 1972). In addition, payments are made for another 30 days after an intent to decertify is announced.

Enforcement of the applicable laws and standards by the public agencies responsible depends to a large extent on the level of staffing of those agencies, policy decisions with respect to techniques of enforcement, zeal in pursuing violators, and the prosecutors' and courts' diligence in following through on the agencies' complaints. In short, this process is time-consuming, expensive (staff time), unreliable (easily abused), and ineffective (U.S. Senate..., 1975).[8]

Private efforts to enforce even those standards which exist are still more limited. Employees are usually unorganized, ruling out collective action. Individual employees are extremely vulnerable to retaliation and usually badly need the jobs.[9] Patients and their families are usually desperately in need of help by the time they encounter the nursing home and therefore in no condition to assert themselves. Frequently they have no idea where to turn with a complaint. They also fear, with ample justification, retaliation against the patient (U.S. Senate..., 1975). Under some conditions, the patient or family may attempt a lawsuit for medical malpractice. Malpractice litigation is an extremely difficult process, however, and few people have real access to it even if they are willing to put up with the problems.[10] When the patient is elderly (as nearly 80 percent of nursing home patients are [U.S. Department of Health, Education, and Welfare, 1975]), malpractice litigation is particularly difficult because the potential dollar amount of recovery is based in part on the potential earnings of which the malpractice victim was deprived by the act of malpractice. In short, for most nursing home patients, this enforcement route is effectively nonexistent.

Under the current structure of the nursing home industry, the normal forces of the market place create incentives which impede the achievement of government's stated policy objectives. They do

[8] California has instituted a tougher system, but there has not yet been enough experience to evaluate the results.

[9] For an example of instructions to nursing home operators for dealing with labor, see Needham (1969: 137-200).

[10] Only those cases with high potential recovery reach litigation, because the lawyer's fee is determined by the amount of recovery, and lawyers do not typically undertake the extensive preparation necessary for successful litigation unless the fee will make it worthwhile.

this by forcing resources into the area of fixed costs (capital facilities) rather than variable costs (such as labor and food). In nursing homes, to a greater degree than in some other health care settings, the most important determinants of the quality of care are items of variable cost: the size of the labor force, the level of capability of the labor force (trained workers are more expensive than untrained ones), adequacy of diet, etc.[11] When these variable cost items are underfunded, patient care suffers. To understand the nature and functioning of these incentives, we have to move from the broad picture of the industry to a financial model of a typical nursing home bed.

Financial Model of a Typical Nursing Home Bed

The nursing home industry is capital-intensive; that is, the industry generates lower annual revenues than the capital required to generate those revenues. Much of the capital intensity is *not* due to investment in active capital equipment, but rather to investment in real estate.[12] In many ways, a nursing home is analogous to an investment in an apartment building or hotel. The financial model for a typical nursing home bed (see tables below) demonstrates that the Medicare/Medicaid reimbursements serve to validate the *real estate* value of a nursing home.

The model assumes that the nursing home bed is owned and operated on a for-profit basis, since three-fourths of all U.S. nursing home beds are so owned and operated. Although this model is incomplete to the extent that there are non-profit operators in the field, it does include those nursing homes owned by individual operators, by tax shelter syndicates, and by corporate chains.

The financial model is based on a composite taken from the Securities and Exchange Commission Forms 10K for National Health Enterprises, Charter Medical Corp., and Beverly Enterprises. These three publicly held companies control approximately 18,000 nursing home beds. Because the data were taken from forms for 1972 and 1973, investment and revenues are understated in terms of today's costs.

[11] In hospitals, for instance, complex and expensive equipment (capital) may be at least equally important in determining the quality of care available.

[12] In contrast, the utility industry (also capital-intensive) requires proportionately heavy investment in production equipment.

TABLE 1
Investment
(Typical Nursing Home Bed)

1. Land	$ 500
2. Building	7,500
3. Total investment	$8,000

TABLE 2
Financing
(Typical Nursing Home Bed)

1. 9½%, 30-year first mortgage	$5,600[a]
2. 12%, 20-year second mortgage	1,400
3. Total debt	7,000
4. Owner's equity	1,000
5. Total investment	$8,000

[a]70% of total investment

Table 1 shows the investment required per bed; and Table 2 shows how that typical bed is financed.

This typical nursing home bed generates net revenues of $16 per day, after an allowance-for-vacancy factor of approximately 8 percent (Standard and Poor's Industry Surveys, 1975).

Table 3 shows the annual income statement for the typical bed.

At first glance, Table 3 appears to show that the nursing home bed is only marginally profitable. A 4.1 percent profit margin, derived from pre-tax income (line 8) divided by net revenues (line 1), is lower than the profit margin in most capital-intensive industries. The 12 percent return on owner's equity can be considered a "normal" return in these days of high interest rates and is consistent with Medicare reimbursement rates. If, as the table appears to show, return on investment was "normal" and in line with those in other industries competing for the investor's money, we would not be able to explain the rapid growth in the private nursing home industry. However, the income statement shows only part of the picture. For a more realistic understanding, we need in addition to examine a cash-flow statement, depicting the amount of cash the nursing home bed is generating. Real estate attracts a sizable num-

TABLE 3
Annual Income Statement
(Typical Nursing Home Bed)

1. Net revenues @ $16/day	$5,840
2. Less: operating expenses	4,678
3. Net operating income	1,162
Capital Costs	
4. Depreciation (3% of building)	225[a]
5. Interest on first mortgage	530[b]
6. Interest on second mortgage	167[b]
7. Total capital costs	922
8. Pre-tax income (net operating income minus total capital costs)	240
9. Less: income taxes (approximately 50%)	120
10. Net income	$120[c]

[a]Assumes 33⅓ years useful life of building (Table 1, line 2).
[b]First year's interest; thereafter it is lower.
[c]Assumes a 12% return on equity equal to one and one-half times the U.S. Treasury long-term bond interest rate as prescribed by Medicare.

ber of investors; one of the main attractions of real estate as an investment is that it produces tax-sheltered cash flow, which can be used for other investments. Cash flow is the key factor in the evaluation of most real estate.

Table 4 shows the cash flow statement of our typical nursing home bed.

In comparing the income statement with the cash-flow statement, the most important numbers are the ones which appear in only one table. The income statement, which lists income and expenses for tax purposes, includes depreciation (Table 3, line 4). Depreciation is a deductible expense for tax purposes and is based on historical cost. The higher the cost, the higher the depreciation deduction.[13] The cash-flow statement does not include depreciation because depreciation does not require cash outlay. Depreciation is only a bookkeeping deduction for allocating the building costs of Table 1. On the other hand, the cash-flow statement includes (but the income statement does not) an amount for repayment of the principal as well as the interest on the mortgage. Interest on the mortgage is deductible for tax purposes, but repayment of principal is not. (Repayment of principal is considered a capital tran-

[13] This tax-accounting notion can lead to the repeated sale of nursing homes at ever higher prices with Medicare reimbursing at ever higher rates. As long as Medicare/Medicaid reimbursements are sufficient to cover this "higher" depreciation, the higher sale price of the nursing home is validated.

TABLE 4
Annual Cash Flow Statement
(Typical Nursing Home Bed)

1. Net operating income (Table 3, line 3)		$1,162
Less: Cash Costs		
2. Interest on mortgages (Table 3, lines 5 and 6)	$697	
3. Principal amortization	53[a]	
4. Total mortgage payments	750	
5. Income taxes (Table 3, line 9)	120	
6. Total cash costs		870
7. Net cash flow (after tax)		$ 292
8. Percentage of owner's equity (Table 4, line 7, divided by Table 2, line 4)		29.2%

[a]First-year amortization; higher for later years.

saction, which is neither income nor expense.) Thus, repayment of principal does not appear in the income statement as an expense, but it does appear in the cash-flow statement because it requires the outlay of cash.

As long as the depreciation is larger than the amortization of principal, the nursing home is generating cash flow in excess of net income. Cash flow can thus be positive while net income is negative.

Table 4 shows that our typical nursing home bed generates cash at the rate of 29 cents per dollar of investment. This is considered a very high return in both real estate and non-real-estate circles. This high return accounts for the large amount of capital attracted to the industry and thus for the industry's growth.

The cash generated is now available for whatever the owner may choose to do with it: investment in additional beds, distribution to the owners, or investment in other types of property. Beverly Enterprises, for instance, used its cash flow to invest in second-home developments in northern California.

Implications

The financial model demonstrates that the factor that attracts capital into the nursing home business is not net income but net cash flow. Net cash flow is based in large measure on the depreciation deductions which are bookkeeping matters unrelated

to a reduction in economic value, not real cash outlays. Thus, in order to increase net cash flow, the nursing home entrepreneur wants the highest possible depreciable basis per dollar of owner's equity.

Once the depreciable basis is in place, the entrepreneur seeks to maintain a net operating income sufficient to cover his or her mortgage payments. This process validates the market value of the nursing home real estate by assuring a tax-sheltered cash flow to the owner.

There are only two ways to accomplish this: maximize income and/or minimize expenses. To maximize income, the operator will try to maintain high rates of occupancy and to promote increases in the reimbursement rates under Medicare and Medicaid. To reduce expenses, the operator will try to cut those costs which are flexible enough to cut, specifically operating costs.[14] This can be done by using low-cost labor, by providing only a minimal diet, and by skimping on all sorts of services including maintenance. In the current economic climate, when state legislatures are especially reluctant to spend additional funds, the only practical method is to reduce operating expenses to the barest minimum. (The same economic climate that makes legislatures reluctant to raise reimbursement rates also makes them reluctant to allocate additional funds to inspection of nursing homes and processing of complaints and violations.)

Although some reductions in operating expenses may well be justified economies, evidence presented to the various investigations of nursing home care suggests that this tendency to reduce operating expenses has very serious health care costs and human consequences. In order to retain control of the nursing home, the operator must maintain a net operating income sufficient to cover the mortgage payments. This is true for all real estate. However, because of the unique Medicaid payment process for nursing homes which generally makes it difficult to increase prices (rent) in the short run, the operator has no choice but to minimize operating expenses (refer to footnote 4). It is in the minimizing of operating expenses that the quality of care is reduced. This does not necessarily make the operator a "villain"; the operator is literally forced into this course of action by the economics of the industry as it is presently structured.

From this examination, it is clear that real estate, not patient

[14] Capital costs are fixed and thus cannot be reduced.

care, is the name of the game. We propose to change the game, to permit focus of both the funds and the efforts on the stated policy objectives, namely high-quality nursing home care of patients.

Our Proposal

Capital facilities, specifically real estate, would be owned by government. Management, however, would be carried out by the private sector through a competitive process designed to improve the quality of management and to encourage performance monitoring by private individuals and groups as well as government agencies.

Once capital facilities (and thus also the real estate aspects of nursing home operation) are out of the hands of the operator, the incentives that currently impede provision of high quality care by diverting resources to capital are also removed. In addition, the taxes presently avoided by those investing in nursing home real estate as a tax shelter can also be collected.[15]

Because government has a strong tendency to devitalize any system it runs for any length of time, and because government management prevents competition and its attendant benefits, we stop at public *ownership*. (Considering the extent of government participation in the industry at present, this is actually quite a small step.)

For management, we propose a system of contracts with private management corporations (either profit-making or non-profit). This is similar to non-profit hospitals (such as those owned by religious orders) contracting with private, profit-making management firms for operation of their hospitals. In designing this aspect of the system, the most critical considerations are the contract specifications, the methods of achieving full public exposure of everything that happens during the operation of the system, and the creation of genuine competition.

Contracts would have minimum performance specifications, with bonuses for proven past successes or for arguably beneficial innovations. Contracts would also have specified limited duration, so that at intervals the performance of the contractor could be of-

[15] Although the property taxes now paid by proprietary homes would no longer be collected, an *in lieu* fee could be required. This would offset property tax revenue, but the income previously sheltered in the real estate investment would now be subject to income tax.

ficially and publicly reviewed and the contract again put up for competitive bid. The previous holder of the contract could of course compete for the upcoming contract, along with anyone else meeting certain limited qualifications.

Since capital assets would no longer be required of the private contractor, entry into the business would be relatively easy in terms of capital requirements. This would allow many management groups to enter the bidding process, assuring a high degree of competition. The current system requires a substantial real estate investment prior to licensing.

The contract-award process, with its required new bidding at each interval, would serve as a brake on unforeseen abuses. This system also has the distinct advantage that it permits competing away potential monopoly profits earned by the management company.[16] If "excess" profits are earned, they would presumably be competed away at the next contract award.

The differences between the proposed and the existing system can be seen by returning to Table 3. In the proposed system, we are concerned only with lines 1 to 3. Capital costs are no longer relevant to the operator and thus, in order to fulfill the contractual obligations to provide care, the operator is concerned only with line 2 (operating expenses). This is, in fact, the only item which is involved in the contract. As long as the operator fulfills its contractual obligations, the state should be satisfied.

Like any owner of a service establishment, government would remain responsible for the quality of management provided in its establishments even though it did not itself carry out the management function. Under the proposed system, however, fulfillment of this responsibility would be greatly simplified. The ultimate test of management effectiveness is the quality of care provided to the nursing home patient. Government would have three major ways to ensure the quality of care. To begin with, government would draw up the contract specifications, presumably

[16] This contrasts with California's prepaid health plan (PHP) contracting in several important ways. PHP contractors must either own or contract for substantial capital facilities; nursing home contractors will own none. PHP contractors generally negotiate their contracts with the state on an exclusive, non-competitive basis. Nursing home contractors would compete. In practice, the complete PHP contract file is not generally available to the public. The nursing home bids would become public as soon as the bidding period closed, and the entire file would be public.

using the advice of people who know something about what makes high-quality care. Second, the competitive bidding process for the award of contracts would permit replacing an inadequate manager with a better one. There would no longer be a need for government to prove malice or neglect; the contract would simply end at the specified time with no promises of renewal. Previous holders of management contracts would not have vested rights in those contracts. Since the contractors would have no investment in the facility, changeover to a new contractor would be simple. Inadequate operations would exist, at most, only for the length of the contract. With a well-designed process for review of performance for widespread dissemination of information about what is going on, and for effective public participation, market forces can be used to assist government in selecting those managers who provide high-quality care. Instead of relying only on patients and inspectors for word of contract violations, government would now also have available the resources of competitors for the contract. Firms anxious to succeed in the nursing home management business would have strong financial incentives to report their competitors' failings through the public-review/contract-award process. Thus, the periodic review process could serve as a market test of the efficiency and quality of the care provided.

Finally, the legal relationship between nursing homes and the government would be greatly simplified. Instead of relying on withdrawal of Medicare/Medicaid reimbursements, and in some cases on criminal sanctions, the government would now be in a position to enforce its rights through the civil courts under contract law. This legal process is a great deal easier to implement than the old one, hence the risk to the nursing home operator of violating the contract is substantially greater than before. Failure to fulfill the contract as specified is a breach of contract and subject to civil penalties. More immediately, withholding of the final installment of payment is entirely proper if the contract was not fulfilled.

This system is quite similar to the franchise bidding system outlined by Demsetz (1968) in his proposal for the utility industry. Although there are substantial differences between the nursing home industry and the utility industry, there are strong similarities: a long history of government regulation, essentialness of the service, and the relatively high proportion of total assets invested in capital facilities. Demsetz's system requires two explicit assump-

tions: (1) the inputs required to enter production must be available to many potential bidders at prices determined in open markets, and (2) the cost of collusion by bidding rivals must be prohibitively high.

Our proposal for nursing homes would, we believe, meet those conditions, first, by the elimination of substantial capital requirements as an entry barrier, and second, by the large number of facilities within a given market area. Also the periodic-review process, coupled with the ease of entry, would tend to mitigate against collusion by bidders. In addition, monopolistic control on the capacity of the industry would be exercised by government, thus preventing overbedding in some areas and underbedding in others, greatly simplifying the organization of health planning and presumably reducing overall system-wide vacancies.

Under this structure, we are out of the real estate net-cash-flow arena. With that change, the incentives which currently impede provision of high-quality care by diverting resources to capital are also removed. With these out of the way, it is now possible for both government and the private sector to address the stated public policy objective of high-quality patient care. If, as a nation, we are still unable to solve the major problems which currently plague nursing home patients, we will have to examine whether the stated public policy objectives are in fact the real public policy objectives.

David Shulman, PH.D.
University of California at Riverside
Graduate School of Administration
1900 University Avenue
Riverside, California 92502

Ruth Galanter, M.C.P.
National Health Law Program
10995 Le Conte Avenue
Los Angeles, California 90024

References

Code of Federal Regulations (CFR)
1972 Employees Benefits, Volume 20. Washington, D.C.:U.S. Government Printing Office.
1973 Public Welfare, Volume 45. Washington, D.C.: U.S. Government Printing Office.

Demsetz, Harold

1968 "Why regulate utilities?" Journal of Law and Economics 11 (April): 55-65.

Needham, Roger A. (ed.)

1969 Nursing Homes: Legal and Business Problems. New York: Practicing Law Institute.

New York Times

1975 New York Times Index 1974, Volume II. New York: New York Times.

Standard and Poor's Industry Surveys

1974 Health Care. H 23. New York: Standard and Poor's.

1975 Health Care. H 23, 24. New York: Standard and Poor's.

U.S. Department of Health, Education, and Welfare

1975 Long Term Care Facility Improvement Study (July). Washington, D.C.: U.S. Government Printing Office.

U.S. Department of Health, Education, and Welfare, Public Health Service

1974 Health Resource Statistics. Rockville, Maryland: U.S. Department of Health, Education, and Welfare, Public Health Service, Health Resources Administration, National Center for Health Statistics.

U.S. Senate, Special Committee on Aging, Subcommittee on Long Term Care

1975 Nursing Home Care in the United States: Failure in Public Policy. Introductory Report and Supporting Papers. Washington, D.C.: U.S. Government Printing Office.