

Excerpts from *The Economics of Deinstitutionalization*¹

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RESEARCH, POLICY AND EXPENDITURE CONTEXT

Introduction

In the United States policy decisions about deinstitutionalization have been made for a range of reasons related to the well-being of service recipients, litigation, funding, and political considerations. Economic factors have not been nor should they be the primary basis for determining policy on developmentally disability services. However, decisions about institutional downsizing and closure have economic consequences. It is important that research-based information about these consequences is available to policy makers, administrators and advocates, so that deinstitutionalization can be planned and implemented in a rational, economically sustainable manner. This chapter examines the research, policy, and economic context of deinstitutionalization drawing on national data on deinstitutionalization, as well as specific examples of deinstitutionalization in California and Minnesota.

...National Trends in Public Institutional Costs

Public institutions are costly enterprises. In Fiscal Year (FY) 2002 states spent, on average, \$125,746 per public institution resident. In the 20 years between 1982 and 2002, the “real” (inflation adjusted) dollar cost of public institution care more than doubled from \$61,117 (2002=\$1) to \$125,746 (Prouty, Smith & Lakin, 2003).

In the United States rapid escalation in public institution costs began in the early 1970s. Four major factors contributed to this trend. The creation of the Intermediate Care Facility for the Mentally Retarded (ICF-MR) program in 1971 provided, for the first time, federal Medicaid cost

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sharing of 50%-80% of institutional costs under the condition of facilities meeting specific programs, staffing and physical plant standards. In the decade that followed, 88% of all public institution residents were living in units that met ICF-MR standards and received federal cost share. In the process, annual expenditures per resident increased from \$4,635 in 1970 to \$32,759 in 1982, or in inflation adjusted dollars from \$21,458 (2002=\$1) to \$61,117. This was the decade of the most rapid rate of increase in public institution expenditures since national data were first gathered in 1903.

ICF-MR certification costs were not the only factor in this increase. Beginning in 1968 public institution populations in the United States began to decrease steadily. In the years that followed, public institutions had to spread the fixed costs of operating the institutions (maintenance, administration, utilities, etc.) over fewer and fewer individuals. (This issue is examined in more detail later in the chapter.)

...It is hard to determine the relative impact on cost of any one of these factors because for the most part they were not only simultaneous, but also interrelated. By the mid-1980s public institutions became extremely costly in comparison to the average per person costs of 1970, so much that in inflation adjusted "real dollars" (\$1=2002), the expenditures for state institutions in 1986 (\$7.97 billion) was nearly double the real dollar expenditures of 1970 (\$4.18 billion), even though the number of average daily public institution residents had been nearly halved from 194,650 in 1970 to 100,190 in 1986. Not only were public institutions expenditures in 1986 dramatically greater than they had been in 1970, community residential alternatives were consistently found to be 75% to 92% as costly as public institutions for comparable sets of comprehensive services (Ashbaugh & Allard, 1984; Bensberg & Smith, 1984; Jones, Conroy, Feinstein, & Lemanowicz, 1984; Minnesota Department of Public Welfare, 1979; Toche Ross, Inc., 1980).

...Institutional and Community Services: Relative Costs

As noted, the comparative costs of institutional and community costs differ greatly, with average expenditures of \$125,746 per public institution resident in FY 2002, as compared with \$37,816 per recipient of community services financed by the Medicaid Home and Community Based Services (HCBS). But such comparisons can be misleading as institutional and community services differ in many important respects, such as the characteristics of the populations served,

wages rates and conditions of employment, and the array of services provided. Consequently, the most meaningful comparisons of institutional and community service costs may be found in the deinstitutionalization costs literature where similar groups of service recipients receive a similar array of services in institutional and community settings.

Available US studies of both costs and outcomes of deinstitutionalization reveal a consistent pattern across states and over time of better outcomes and lower costs in the community (Jones, Conroy, Feinstein, & Lemanowicz, 1984; Knobbe, Carey, Rhodes & Horner, 1995; Stancliffe & Lakin, 1998), consistent with US deinstitutionalization literature on outcomes (Kim, Larson, & Lakin, 2001), and cost comparison research showing US institutional services to be more costly than community services (Campbell & Heal, 1995; Schalock & Fredericks, 1990).

It should be noted that a primary factor associated with the difference is the consistently and substantially lower wages paid to direct support staff employed by community service agencies. Nationally in 2000, the average hourly wage of direct support staff in state-operated services was \$11.57 versus an estimated \$8.72 (24.6% less) in non-state community services (Polister, Lakin & Prouty, 2002). Such consistent and substantial wage differentials likely have been noted as a major driver of the lower cost of non-state community services (Campbell & Heal, 1995; Rhoades & Altman, 2001; Stancliffe & Lakin, 1998), especially given that staff costs are the largest component of residential and related services expenditures, generally representing about 77% to 87% of total expenditures (Stancliffe & Lakin, 1998). More detailed discussion of issues related to cost comparisons between institutional and community services may be found in Chapter 1 of the volume (Stancliffe, Lakin & Lewis, in press).

COSTS OF CLOSING INSTITUTIONS

Large, State-Operated Facilities

...As populations of public institutions have continued to fall, increasingly specialized roles have been ascribed to institutions. With ultimate closure of public institutions, states must identify the roles and services that the public institutions are providing, so that alternative sources can be established. This often requires systematic analysis of each institutional admission and readmission. Frequently, the roles/services sustaining the institution have relatively little to do with their life circumstances. For example, many public institutions serve as the one place where there is always an open “bed” in times of crisis (death or illness of the primary care provider; unexpected

and immediate demission from community settings). Identifying such roles/services provided by institutions that will still be needed after their closure is an important aspect of the closure process. Likewise, designing those features into the system of community supports as programs or enhanced capacities is an important aspect of institutional closure and represents an additional cost. Probably the most commonly identified function/service needed in support of public institution closure is community-based behavioral support and crisis response (see Hanson, Wieseler & Lakin, 2002), but the nature of the community service needed depends on the analysis of roles and functions of the specific institution to be closed.

Current and Future Issues

In any analysis of public expenditures, including expenditures for services for persons with ID/DD, it must be recognized that ultimately the resources expended are determined much more by resource allocation traditions than by inherent costs. One might note these traditions the variations in expenditures for highways between two states of similar size. For example, Missouri spent twice as much for highways in 1999 than neighboring Arkansas. Such variations exist with institutional and community services. In FY 2002, attempting modest control for diseconomies of reduced scale, the five states (Georgia, Illinois, Iowa, Missouri, Nebraska) with state institution population reductions from 1980 to 2002 in the range of 42.0% to 48.0% had average daily institution costs in FY 2002 that ranged from \$235 (Missouri) to \$334 (Illinois); nine states (California, Delaware, Montana, New Jersey, Ohio, Tennessee, Texas, Virginia, Wisconsin) with state institution population reductions from 1980 to 2002 that ranged from 50.0% to 62.0% had average daily costs that ranged from \$253 (Texas) to \$589 (Tennessee). (Some “traditions” such as Tennessee’s are sometimes recreated in federal courts.) Similarly combining Medicaid ICF-MR and HCBS expenditures for states showed that in FY 2003, states had average combined annual per person expenditures that ranged from less than \$35,000 in nine states to more than \$70,000 in six states. Because there is no “right amount” that services should cost, the amount services do cost are affected by various factors. One set of factors that may well substantially affect expenditures in the next few years is the cost of direct support workers....

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