Home Health Care and the Elderly in the 1980s

(community health services, home care services)

Barbara N. Jackson

Because the cost of institutional care for long-term patients has risen, home health has become a more visible and viable alternative to the growing elderly population. This article discusses problems found in the rapid expansion of home health services and presents two alternative health care delivery systems that address these problems: the Medicaid Waiver and the Social/Health Maintenance Organization.

Home health care is an old idea that has taken on a broader concept in the 1980s. The National Center for Health Statistics reports that the first home care program was developed in Boston in 1796 (1). Except for such prototypes as the home care program developed by the Montefiore Hospital in 1947, there was little development of the home health movement until the enactment of the Title XVIII (Medicare) and Title XIX (Medicaid) Amendments to the Social Security Act of 1965 (2). The largest impetus to use of home health services has been the Social Security Amendments of 1983 (Public Law 98-21), which established a prospective payment system to hospitals for Medicare inpatient costs based on a diagnosis-related group (DRG) system of 467 categories.

Demographics
The “graying” of America has significance for health planners. A U.S. Department of Health and Human Services publication (3), The Need for Long Term Care: Information and Issues, distributed prior to the 1981 White House Conference on Aging, stated the following.

During the 1980’s the number of Americans 65 and over will increase from about 25 million to 30 million. The rate of increase in the elderly population between 1990 and 2010 will be slower than the previous decades. Then the rate of increase will surge explosively between 2010 and 2030 when the baby boom becomes elderly.

The Black elderly population is increasing faster than elderly white generally in each sex group and in each elderly subgroup. Female longevity over males reflects the fact that many elderly are no longer married and live alone or with unrelated individuals, and are concentrated in the low-income brackets.

Three million elderly were living below the poverty level in 1978, when an elderly person was counted as poor if income did not exceed $3,116. Families headed by females were five times more likely to be poor than those headed by males.

Thus, the elderly who are most at risk of needing health care are poor women who live alone or with nonrelated individuals. Traeger (4) stated that only 10.7% of the American population is more than 65 years old; however, 22.2% of this group have annual incomes that place them at or below the poverty level. This poverty includes having the stresses caused by bad housing, poor nutrition, and little family support—all of
Because they pertain to cost, accessibility, and delivery, these demographic changes in the elderly population of the 1980s are at the center of home health care reform.

which are additional health risks. Older people who live in rural communities where social and health supports are limited are more likely to be chronically ill and disabled than those in urban areas.

Problems of Home Health

Because they pertain to cost, accessibility, and delivery, these demographic changes in the elderly population of the 1980s are at the center of home health care reform. A major problem in the Medicare and Medicaid legislation is that it describes which services will be reimbursed by the insurance system, but it fails to define what constitutes home health care.

The 1965 Medicare regulations stated that home health care services were reimbursable if there was a primary need for "skilled" nursing care or if there was a need for part-time or intermittent services after a three-day hospitalization, if the patient was homebound, and if the total number of visits did not exceed 100. Medicaid had similar requirements but did not have the three-day posthospitalization and visitation limits. It was a medical assistance, state-administered program with a means test for a designated population.

The 1980 Omnibus Reconciliation Act eliminated the three-day hospitalization and the 100-visit limit. It also required approval of Medicare licensure to all proprietary providers according to specific guidelines. However, the Act still kept the requirements of homebound status and of the need for "skilled" intermittent care.

The lack of definition of home health services was addressed in a publication of the National League for Nursing (5).

Home health services may be defined as an array of health care services provided to individuals and families in their places of residence or in ambulatory care settings for purposes of preventing disease and promoting, maintaining or restoring health or minimizing the effects of disability.

Broadening the concept of home health care to include prevention and maintenance services is reflected by the National Association of Home Health Agencies joining with the Council of Home Health Agencies/Community Health Services to form the National Association for Home Care.

Another problem for the expansion of home health services is that Medicare still follows the institutional model. In 1980, payment to home health agencies amounted to slightly more than 1.9% of the total Medicare payments (6). In 1977, the Congressional Budget Office (7) noted the following two reasons for this small use:

1. statutory limitations on the target populations, the types of services that are reimbursable, the conditions of participation for home health agencies; and
2. strict regulatory interpretation of the statute. (p. 27)

The coordination of services is a problem because of the variety, scope, accessibility, and availability of different home care programs. A person in need of home care may have to go to many agencies to obtain a variety of services. Comprehensive home health services are underdeveloped in relation to the population at risk. Callahan (8) suggests that only about 10% of those elderly who need home care actually receive it.

This lack of services coordination is compounded by the fragmentation of funding sources. In addition to Medicare and Medicaid, the Title XX Amendments to the Social Security Act (1974) and the Older Americans Act (1965) provide for some in-home services. These services are administered and delivered at the state and local level, and therefore can vary from state to state. Primarily, Title XX provides social services; however, it also covers some homemaker and health aide services. The Older Americans Act funds projects that foster indepen-
dence in the elderly, for example, Title III, which pays for aides to help the homebound elderly. In addition, the U.S. Public Health Service, through its public health laws such as Public Law 94-63, administers home health developmental and expansion programs(9).

Alternative Community Programs
The Omnibus Budget Reconciliation Acts of 1980 and 1981 addressed the topics of how to assess the patient’s health care needs using a case management system, and how to coordinate the needed services. These acts allowed states to obtain waivers to Medicaid rules in order to pay for home- and community-based services.

One such Medicaid waiver program, designed to assess patients who are at risk of entering a nursing home within six months, is being implemented in North Carolina, under House Bill 405 (10). A preadmission screening committee, consisting of at least one nurse and one social worker or occupational therapist, or both, in consultation with a physician, determines, after a home evaluation visit, if in-home care would enable the patient to stay at home or in the community at a cost not to exceed that of placement in a long-term facility. The assessment form is used to gather both social and health information (e.g., identification and financial data; social and home environment and health information, and a client functioning summary). From this information, the case manager develops a service plan, which is reassessed and evaluated at regular stated intervals.

Various assessment evaluation forms have been developed over the last 20 years. These include the OARS Multi-Dimensional Functional Assessment (11), the Index of ADL (12), and the Long-Term Information Systems (13). However, the reliability and the uniformity of the criteria for placement of the elderly have not been proved (14).

Another project that attempts to coordinate social and health services for the elderly at risk of long-term institutionalization is California’s Multipurpose Senior Services Project (MSSP).

Services provided through MSSP include adult social day care, housing, and home repair, in-home support, legal services, medical respite care, nonmedical transportation needs, nutrition, protective services (e.g., safety escorts), specialized communication (e.g., telecommunication for the handicapped), and preventive health care. (15, p 19)

The S/HMO is expected to create an incentive to provide care in the most appropriate and cost-effective settings by allowing flexibility in service patterns, placing a cap on program expenditures, incorporating case management structures, and emphasizing prevention and nonmedical supports. Medicare is to reimburse the S/HMO for all services covered under Parts A and B, and for incidental services on the basis of a capitated rate per enrollee of 100% of the average adjusted per capita community rate (AAPCC). In addition, private premiums will be charged to make up the difference between revenues and the cost to provide the comprehensive package; this should not exceed the current Medicare supplemental premium. Medicaid subscribers will be covered for all included...
benefits at a negotiated capitation rate.

The S/HMO concept represents most clearly the trend away from the strictly medical model of health care for the elderly, as represented by the Medicare regulations, toward a health care delivery system that includes the personal and social needs of the patient. The countries of Western Europe and Scandinavia, and Canada have made extensive use of the home care model for many years. Preventing the expansion of coverage for home care services in the United States have been the fears of Congress that such coverage will increase costs significantly and reduce free family support. Unfortunately, there are few research studies with empirical data that can document the cost-effectiveness of a home care program for the elderly as an alternative to institutionalization. This is partially because of the difficulty in finding a research design that will include such factors as rent, food, clothing, and free care-giving services in a home care cost analysis.

As consumers, the elderly have stated what they desire in home health care in the 1980s in Recommendation #131 of the Final Report of the 1981 White House Conference on Aging (17).

A full range of home health and in-home services should be developed and available to rural and urban elderly in every community. Title XVIII and Title XIX of the Social Security Act should be modified to allow reimbursement for a variety of in-home services . . . On the federal level, regulations for in-home services and nursing homes should be simplified.

Conclusion

The growing elderly population and the rising cost of health care have necessitated that health planners explore innovative ways to reduce spending on institutional care. Home health is now taking on an expanded role, which includes prevention, health promotion, and maintenance services to provide for the personal and social needs of the elderly.

REFERENCES

5. Administrator’s Handbook of Community Health and Home Care Services, publication No. 21-1943. New York: National League of Nursing, 1984, p 95
10. County Guidelines for Developing a Long-Term Care Screening Program, North Carolina Dept of Human Resources, May 1982