Homemaker Services—Essential Option for the Elderly

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"Mrs. L was admitted to the nursing home on October 2, two days after neighbors learned she had lived for a week on water, a half-load of bread, and a box of cereal. Various infirmities kept her from shopping for groceries and even from preparing meals and she had nobody to do it for her. The kindly neighbors watched as Mrs. L was helped down the stairs on her way to an institution, and their own taxes were helped up. Her care would cost about $400 a month or about three or four times what it would cost to have a part-time homemaker-home health aide to do her shopping, help with her meals and do her housekeeping. Such help was all Mrs. L needed and all she wanted."

THE PRECEDING VIGNETTE appeared in an American Medical Association news release on March 16, 1973. Three years later, hundreds of thousands of persons such as Mrs. L are still being sent to nursing homes, even though less-expensive in-home services are often all that they want or need.

According to the U.S. Senate's Subcommittee on Long-Term Care (*1*):

> If home health services are readily available *prior* to placement in a nursing home there is convincing evidence to conclude that such care may not only postpone but possibly prevent more costly institutionalization. What is particularly appealing from the standpoint of the elderly is that home health services can enable them to live independently in their own homes, where most of them would prefer to be.

The subcommittee reached this conclusion after 15 years of study of long-term care and the testimony of hundreds of witnesses, representing both professionals and consumers. Other studies make the same point. For example, Prof. W. G. Bell, of Florida State University, found that 85 percent of the elderly surveyed in one county, including those in nursing homes as well as those at home, preferred to be at home (*2*).

In-home services can also lead to faster discharges after hospital or other institutional care. Hospital utilization review committees are under increasing pressure to find safe alternatives for many persons who no longer need hospital care. New York State now mandates an "organized discharge planning program . . . acceptable to the Commissioner [of Health] and in writing to ensure that each patient has a planned program of continuing care which meets the patient's post-discharge needs" (*3*). Homemaker-home health aide services can be an essential component in such "a planned program of continuing care."

Such services are also often needed by the disabled and by families with small children when the mother is incapacitated for one reason or another. In fact, homemaker services began as a substitute mother service in the early part of this century. The hyphenated title, "homemaker-home health aide," results from superimposition of the term "home health aide," which was formally introduced in title XVIII of the Social Security Act of 1965 (Medicare), on the older term "homemaker." In this paper, we generally use "homemaker" in lieu of the longer title. Also, since homemakers now provide more services to the elderly than to families with children, the focus is on this aspect of their work.

The number of agencies providing homemaker services is growing, but not fast enough in relation to need. In 1975, fewer than 1,800 administrative units were providing homemaker services, and fewer than half of these were among the 2,300 certified home health agencies. The number of homemakers is estimated at about 44,000. The National Council for Homemaker-Home Health Aide Services places the need at 300,000, approximately 1 for every 1,000 Americans under 65 and 1 to 100 for those 65 and over.

Currently, in the United States there is 1 homemaker for every 5,000 persons, a very low ratio compared with other industrialized nations such as Norway, the Netherlands, Sweden, or the United Kingdom. Sweden has the highest ratio, with approximately 1 aide for each 121 persons. Norway has 1 to 173; the Netherlands, 1 to 247; and the United Kingdom, 1 to 726. The United Kingdom leads with the greatest absolute number: 67,440. Sweden has 65,700, the Netherlands, 52,130, and Norway, 22,231 (*4*).

Tasks and Qualifications of Homemakers

Working under supervision of a health professional, the homemaker helps older people—those with arthritis, heart conditions, or terminal cancer, or those who are simply too old or too frail to keep house and care for themselves adequately—with personal and household tasks which they can no longer do for themselves. Included are laundry, shopping, preparing nutritious meals, bathing, shaving, and washing hair. Under supervision of a therapist, the homemaker may also assist with a physical, speech, or occupational therapy routine. She provides emotional support, and she observes and reports the patient's condition to the public health nurse or other supervisor.

Note that both personal care and household tasks are included. Most homemaker agencies see no reason, other than the reimbursement requirements of Medicare and other third parties that follow the Medicare model, for separating these closely allied functions.

The formal definition developed by the national council assumes both types of activity:

> Homemaker-home health aide service helps families to remain together or elderly persons to remain in their own homes when a health and/or social problem occurs or to return to their homes after specialized care. The trained homemaker-home health aide, who works for a community agency [which could be a hospital], carries out assigned tasks in the family's or individual's place of residence, working under the supervision of a professional person who also assesses the need for the service and implements the plan of care.

Periodic patient assessment and reassessment are particularly important in these days of malpractice fears. The assessments should of course be done by appropriate professionals; for example, medical appraisals by physicians, phsyical therapy assessments by physical therapists, and nursing assessment by nurses.

The services of homemakers should be seen as part of a broad spectrum of in-home services which include medical care, nursing, physical and speech therapy, social work, nutrition, and a host of paraprofessional or

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volunteer services, such as telephone reassurance, friendly visiting, meals-on-wheels, and transportation. In a given community, these services should be administered by a single agency, or agencies providing services should be linked through a federation or council or through a case manager employed by one agency. Such coordination is necessary to assure maximum utility, flexibility, and economy for any one person or family.

Although the homemaker should always work under supervision of a nurse, social worker, or other professional, she is usually a mature woman. Personal qualifications, such as maturity, warmth, integrity, and experience, are much more important in this work than formal education. Since long-term training, or even a high school diploma, is not needed, the homemaker job is ideal for many unemployed women, particularly those who have raised families of their own. It offers a useful opportunity for employment and training under the Comprehensive Training and Employment Act of 1973, which is being used for this purpose in some localities.

Standards and Accreditation

If the homemaker field is not to go the way of the nursing home field, proper attention must be given now to standards and adequate monitoring. Each agency's performance should be monitored by a properly qualified body, either a national voluntary organization such as the National Council for Homemaker-Home Health Aide Services or a department of State government.

In 1965, the national council developed a set of standards as a basis for a national approval program (*5*). Topics covered included the organization and administration of a homemaker-home health aide service, staffing, orientation, ongoing training programs, records, and community relations. The approval and monitoring program, based on these standards, was first implemented in 1972. Currently, nearly 100 homemaker programs across the nation are recognized, and the national council program is gradually moving toward a national accreditation system, with links to the home health agency accreditation of the National League for Nursing-American Public Health Association and national social service accrediting organizations. Similar collaborative efforts are under discussion with the Joint Commission on the Accreditation of Hospitals.

Other professional groups, including the AMA, have endorsed homemaker services and the national council in its leadership role. The American Cancer Society has recognized the need for quality homemaker service for patients with cancer. The National League for Nursing and the American Hospital Association each have a home health services department, and a new voluntary organization has emerged on the national scene, the National Association of Home Health Agencies.

In the public sector, the national council's standards are serving, in whole or in part, as models for State departments of social service, aging, health, mental health, and rehabilitation. The council's standards also supplement the home health aide aspect of the Medicare home health certification process. Unfortunately, there is no reference to standards for homemaker services for the aged, blind, and disabled in the social services program established under the Social Services Amendments of 1974 (title XX). This gap in official standard setting provides a special challenge to the voluntary field.

The growing interest and concern for homemaker services augur well for eventual expansion and assurance of quality. Meanwhile, vigorous discussion about in-home services and ways to resolve the issues that hinder their development must take place in the public arena as well as in professional circles. Among these issues, one of the most urgent is financial support.

Costs and Financing

The cost effectiveness and even the cost of home care, including homemaker services, have been debated for some years. Advocates of home care point to the high and still rapidly rising costs of institutional care and contrast these figures with the relatively low hourly or per-visit costs of in-home services. For example, unpublished data reported to the national council by 74 approved programs—primarily voluntary, nonprofit, but from all sections of the country—indicate a 1974–75 average cost per hour for homemaker services of $5.28. This includes homemaker salaries and benefits, supervisory and other administrative costs, and some costs of professional assessment. (For some of those served, the costs for professional assessment are lodged with the contracting agency.) For the 74 programs, the average number of hours per case in that period was 122; and the average cost per case, $644.

Spokesmen for nursing homes, as well as objective observers, point out that such figures are incomplete and can be misleading. Obviously, all services essential to maintaining a person in the home must be compared with all services essential to maintaining a person in an institution. One Maryland nursing home administrator recently put the counterargument this way (*6*):

> As for the cost of home care, it costs upwards of $45 per shift for private duty care in the home plus ancillary costs such as equipment, nutrition, transportation, etc. In addition, to have a visiting nurse come to the home for one hour would cost approximate $25. This does not include the homemaker, physical therapist, or occupational therapist fees if needed. . . . In reality, home care will cost more than inpatient care both in terms of money and human resources. It may be sociologically acceptable, but we must be ready to pay the price.

Such a view is a useful antidote to too-facile or purely ideological acceptance of home care as a universal cost-effective alternative. However, it is also misleading, in the opposite direction; the implication is that home care requires constant, rather than intermittent, attendance. A patient in need of around-the-clock private duty nursing is rarely a suitable candidate for home care. Even the visiting nurse will not usually

come in every day; sometimes she will be needed only once in 10 or 15 days. For example, 3 large approved urban agencies with 1,000 patients 65 years of age and over (San Francisco Home Health Service, Inc., Home Aid Service, Cincinnati, Ohio, and Homemaker Health Aide Service of the National Capital Area, Inc., Washington, D.C.) report that utilization of homemakers averages less than 25 hours a month per patient, plus fewer than 2 professional visits a month. The professional visits include all related responsibilities such as assessment, supervision, and coordination with other community resources.

Additional data are needed based on a uniform recording and reporting system. Information on utilization patterns and comparison of like services is essential to the clarification of the cost issue. The crucial test, however, is the appropriateness of the care to the needs of the individual patient. A patient who needs 24-hour-a-day service usually should not be cared for at home; one who needs only intermittent services usually should not be in an institution. The complexity of services also has to be considered. In other words, we believe each type of care can be cost effective when appropriately used. Among the individuals and groups endorsing this view are the Comptroller General of the United States (*7*), the Health Insurance Benefits Advisory Council to the Secretary of HEW (*8*), the U.S. Senate's Subcommittee on Long-Term Care of the Special Committee on Aging (*1*), Senators Frank Moss and Frank Church, chairmen of these two committees, and Representative Edward Koch of New York (*9*).

According to the Comptroller General (*7*),

> Several studies—focusing on savings realized by early transfer of patients from hospitals to home care programs—have pointed out that such care can be less expensive than institutional care. . . .
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> A study by the Rochester, New York, Home Care Association showed an estimated reduction of 13,713 patient-days and a savings of $1,055,000 in calendar year 1970 and an estimated reduction of 12,579 days and a savings of $1,068,000 in calendar year 1971 as a result of early release of patients from hospitals to home health programs.

The Senate subcommittee stressed the role of home health services as an alternative to institutional care and cited the following example provided by the Minneapolis Age and Opportunity Center (*1*):

Supportive services for Mrs. MR for 3 years by MAO:	
Meals, including delivery charge (2 meals a day, 7 days a week)	$3,385.00
Housekeeping services (3 services a month)	399.60
Counseling (average 1 session a month)	324.00
Total cost of MAO services	4,108.60
Nursing home costs for 3 years (projected):	
$450 per month	16,200.00
Less client's income of $115 a month (client allowed to keep $25 a month for personal needs)	−4,140.00
Remaining cost to be paid by Medicaid	12,060.00
Less cost of MAO services	−4,108.60
Total MAO saved taxpayers over 3 years	$7,951.40

This example has been criticized on the grounds that only support services were included and some health care might have been needed in addition. There are two answers to this: (*a*) many patients in nursing homes today need only support services and (*b*) institutionalized patients who require medical or special therapeutic attention are frequently charged additionally for these services.

In its own cost study, the national council stressed the potential economy resulting from the greater flexibility inherent in home services (*10*):

> Institutional care, which requires that employees be on duty around the clock, cannot easily be varied nor does it allow individuals to do as much for themselves as possible. In-home care, on the other hand, can be custom-fitted to the needs of the individual and families served, while simultaneously making the most of their strengths. For example, the hours a week of care, the duration of care, and the tasks performed by the homemaker-home health aide all can be fitted to the need and can be changed to meet a changing situation.

Despite this agreement on potential cost savings as well as the strong preference of most of the elderly to remain in their own homes, health care in the United States remains heavily institution oriented. A major explanation for this fact, as well as the striking differences between homemaker-population ratios in the United States and European countries, is the relatively low level of U.S. Government support. A beginning toward Federal support was made in the 1962 social services amendments to the Social Security Act, and titles XVIII and XIX of the 1965 law provided some funding for home health services, including "to the extent permitted in regulations, part-time or intermittent services of a home health aide." Medicare permits reimbursement of home health aide services, however, only if skilled nursing, physical therapy, or speech therapy is also required by the patient.

Over the years, the Social Security Administration has interpreted the provision of home health aide services very strictly. Only personal care services for the patient, not housekeeping duties, are reimbursable, unless the housekeeping is incidental and does not increase the time spent by the home health aide. In contrast, the equivalent of many household services such as food preparation, laundry, and cleaning are included in institutional reimbursable expenses. Although Medicaid is less restrictive, the constant financial pinch felt by that program, especially at the State level, and the pervasive influence of the Medicare pattern have resulted in a similar downgrading of home care. It is not surprising that all home health programs account for less than 1 percent of Medicare expenditures and an estimated 0.4 percent of Federal-State expenditures under Medicaid. This situation has been severely criticized by the Comptroller General, the Health Insurance Benefits Advisory Council to the Secretary of HEW, and the U.S. Senate's Special Committee on Aging.

One result of such criticism is the establishment of several experimental home care and homemaker projects under section 222 of the Social Security Amendments of 1972 (Public Law 92–603). The Division of Long-Term Care of the Health Resources Administration, Public Health Service, is funding the development, operation, and evaluation of these projects, with Medicare and Medicaid allowing reimbursement for the cost of services. Among the most important of the projects is a national test to help develop a proposed homemaker benefit for Medicare part A. Since May 1975, four homemaker programs have been providing a defined list of services to patients discharged from hospitals and attempting to establish precisely the cost and cost effectiveness of such services. The programs, all of which meet the national council standards, are the Homemaker-Home Health Aide Services of Rhode Island, the San Francisco Home Health Service, the Lexington-Fayette County (Ky.) Health Department, and the Inner-City Home Health Association, Los Angeles. The research is scheduled for completion by the end of 1976, and the results are to be made available by mid-1977.

A similar struggle over reimbursement is taking place in the private health insurance industry. Blue Cross and commercial carriers are gradually including some homemaker services as covered benefits, with carefully worked-out limitations. Unfortunately, these developments have generally followed the Medicare model. The overall result is that while some lower-income persons obtain in-home service through public social service and health programs and some well-to-do persons may purchase service from the rapidly developing proprietary homemaker agencies, the middle-income group is generally left without an adequate funding source.

Need for a National Policy

Although the reluctance of third-party payers, especially Medicare, to reimburse for homemaker services is the most visible obstacle to expansion, it is only the tip of the iceberg. Indeed, the Medicare restrictions are themselves the result of other deep-seated obstacles. Among these are the overwhelming priority that physicians and most other health professionals give to care for acute illnesses, rather than to prevention and management of chronic illness; the fact that most "health insurance" is in reality "sickness insurance"; the fear, among both public and private third parties, of abuse of noninstitutional care, which, it is widely believed, is more difficult to monitor than institutional care; the tremendous investment in acute-care hospital beds, nursing homes, and other institutional facilities, an investment which virtually mandates high occupancy as a measure of acceptable productivity; and changing consumer attitudes, mores, and lifestyles. The typically small urban apartment, the fewer children to share the burden of providing a home for aging parents, and crime and the fear it engenders among older people living alone all militate against the philosophy of home care.

Underlying most of the provider and third-party concerns is the virtual impossibility of establishing a neat boundary between health care and other needed services. The homemaker-home health aide services concept is caught in the middle of these basic philosophical and societal conflicts. The awkward hyphenated name, a product of the effort to link needed social services with reimbursable health services, symbolizes the dilemma. While we Americans continue to give lipservice to one set of values—individual autonomy and responsibility, the family, the community, prevention, and health maintenance—all the major incentives—financial, professional, and status—are aimed in the opposite direction.

But there is some reason to believe, or at least hope, that the priorities may now be changing. The Senate Subcommittee on Long-Term Care is beginning to crystallize and mobilize public and professional opinion (*1*):

> A national policy on long-term care—comprehensive, coherent, and attentive to the needs of older Americans—does not exist in the U.S. today. The need for such a policy becomes more evident with each passing day that brings an increasing number of older Americans. The rapid increase in America's over-75 population indicates that (1) a policy is needed immediately, and (2) long-term care should properly be considered within the context of national health insurance plans.

The importance assigned by the subcommittee to home care as an alternative to institutionalization is also made clear:

> Home health care receives a very low priority in the U.S. . . . this glaring lack of policy is all the more evident when American health delivery systems are compared with some European systems where home health is a full partner in a genuine continuum of care. . . .
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> Older Americans, more than any other group, have been adversely affected by the failure. Some 2.5 million seniors are without necessary care, which could postpone or prevent institutionalization if provided in a timely fashion. Moreover, it could allow elderly persons to live independently, in their own homes, where most would prefer to remain.

Within this "genuine continuum of care," the desirability of appropriate, approved, carefully supervised homemaker services, a key component of long-term noninstitutional care, can be related to four separate but reinforcing considerations:

1. Homemaker services provide an essential option to the infirm elderly, the disabled, and the handicapped who need some assistance with personal and household tasks but do not need institutional care. Such services permit them to remain in their own homes where most prefer to be, with families as nearly intact as possible.
2. Homemaker services provide needed assistance to overworked health professionals, often permitting them to care for patients in their own homes with fewer time-consuming visits to the homes.
3. Homemaker services provide an opportunity for useful work to mature persons with homemaking experience, without the necessity for much formal education, thus suggesting a major opportunity for public-service

jobs, as well as private employment, during the years of anticipated high unemployment immediately ahead.

4. Homemaker services often provide an opportunity for substantial savings to third-party health insurance carriers and taxpayers. The urgency of this point is underscored by the rapidly rising number of the elderly and their generally low income status. In mid-1975, there were 22.4 million persons 65 or over, 10.5 percent of the population (*11*). By 1985, the figure is expected to reach 26.7 million, and by 2000, 30.6 million (*12*).

Although substantial overall savings with home care are possible only if there is a moratorium on construction of unneeded hospital beds and other institutional facilities, there is reason to hope that national policy is gradually changing in this respect because (*a*) there is now less public subsidy of institutional facilities, and (*b*) planning mechanisms designed to encourage rational allocation of health care resources are gradually coming into existence through the new National Health Planning and Resources Development Act and State certificate of need laws.

Recommendations

In the hope that the leadership of the health professions, in cooperation with government and consumer representatives, will help the homemaker services meet their full potential, we recommend the following immediate steps:

1. Agree on a definition of homemaker service that recognizes the inclusion of both personal care and household tasks and covers benefits and eligibility.

2. Agree on standards to assure appropriate, safe, efficient, and effective services, and on one or more mechanisms for approval or accreditation of programs meeting such standards.

3. Extend—through amendment of the Medicare "Conditions of Participation," State regulations, or both —the policy contained in the New York State Hospital Code requiring every hospital to maintain an "organized discharge planning program . . . which meets the patient's post-discharge needs" (*3*).

4. Agree on basic recordkeeping and accounting procedures to provide an essential data base for quality controls and for actuarial estimation of the costs of insurance coverage.

5. Implement the recommendations of the Senate Subcommittee on Long-Term Care, the Comptroller General, and the Health Insurance Benefits Advisory Council with respect to benefits for home health services under Medicare and Medicaid.

6. Encourage voluntary coverage of home health services, including homemaker services, in Blue Cross and other private health insurance, and explore with all interested parties the desirability of mandatory coverage.

7. Formulate a realistic package of home health benefits, including coverage of homemaker services, to be included in national health insurance when enacted.

8. Encourage employment and training of homemakers under the Comprehensive Employment and Training Act of 1973 and other public service employment programs as a means of providing useful jobs and skills for the unemployed, as well as attracting much needed recruits, especially to work in low-income areas.

Conclusion

Health professionals, consumers, and governments must recognize that much more is involved in health than just health care, no matter how broadly the latter is defined. Environmental and behavioral threats to health are inherent in many conditions of contemporary American society, particularly the decline of the family and the family homestead, the distintegration of communities, the prevalence of violence and fear, and overreliance on institutionalized care. Obviously, homemaker services alone cannot stem this tide. They symbolize, however, the need for reintegrating health, welfare, and community services as they apply to the individual and to the family.

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