International Innovations in Home Care

by Abraham Monk, Ph.D. and Carole Cox, DSW*

The demand for community-based services for the frail and aged and the disabled, such as home care, has been increasing relentlessly in the United States as in other countries. Between 1977 and 1986, the Federal Government’s bill for home health care under the Medicare program expanded 2000%, from 100 million to 2 billion dollars. By 1986, home care had already grown into a 5 billion dollar industry, half of which was publicly financed. It is anticipated to reach a total of 18 billion by the year 1990.

The number of home care agencies similarly increased from 1275 in 1966 to an estimated 10,000 in 1986, with 50% of the increase taking place just after 1982. However, this rapid development has occurred without real systematic planning.

Home care in the United States is characterized as a fragmented and disjointed patchwork of programs because services respond to several streams of funding with restrictions and variations in eligibility. The search for a more viable and feasible model of home care prompted the Administration on Aging of the United States Department of Health and Human Services to fund a study of home care services in six countries, which we conducted between September 1987 and June 1989.

The study aimed to examine successful program models and innovations in home care currently taking place in England, Canada, Sweden, Norway, the Netherlands and Argentina. These countries were not chosen at random. We had first obtained information about policies, organizational structures and creative strategies in service delivery in many nations before targeting these for their interesting and varying approaches to home care.

As a single perspective study, we selectively screened out community care and home care for the elderly from the broader range of gerontological services. Yet, we tried to treat the subject matter in a systemic way by constantly referring it to its broader policy and cultural underpinnings.

The findings of the study are not meant to be used as instant prescriptions for replication. Their significance rests more on the holistic portrait of how six national societies approach long-term care issues, rather than on the representation of piecemeal methods and techniques.

Definition of home care services

In all six countries home care services include domestic, personal care, nursing and medical care. In general, home help and home nursing are the two dominant types of community services offered to the elderly. Moreover, home help may even be further divided into regular domestic assistance and heavy duty cleaning, as is the case in Sweden or in parts of Manitoba. Services in the array of home care may thus include dressing and personal care, assistance with medications, shopping, cleaning, laundry, meal preparation, errands, socialization, and escorting of the older person to various appointments.

The programmatic distinction between home help and home nursing, which historically led to two separate administrations of services, is giving way in some Norwegian municipalities to experimentation with a more “syncretic” model. Home helps are thus trained to perform some nursing aid services, and work in teams with nursing personnel. Professional boundaries are beginning to give way to a more undifferentiated or generic form of home assistance.

Governmental Policies

All countries studied have adopted specific government policies giving primacy to home care and recognizing it as a viable and significant program in the long-term care continuum. These policies are based upon three premises: that home care is less expensive than institutional care; that the elderly themselves prefer to remain in their own homes; and that institutional care is intrinsically deleterious to the well-being of older persons. Some national policies go as far as to aim for the limitation and even dismantling of institutional care. Because governments are the primary funders and, in some cases, even providers of institutional care, potential savings realized through home rather than institutional care become a more salient although not always explicit goal.

There are variations among countries regarding the role of the central and local governments in establishing policies and operating home care programs. Some tend to operate services in a tightly centralized fashion. Argentina, for instance, operates home care through a federal agency with little participation of state or local governments. Manitoba, Canada, has a centralized provincial home care program, with uniform regulations applicable to all regions. There are standardized guidelines for services to which local offices must adhere.

*Abraham Monk is Professor and Director of the Institute on Aging, Columbia University School of Social Work in New York. Carole Cox was Research Associate, Columbia University at the time when the study was conducted. She is presently at Catholic University of America in Washington, D.C.
Decentralization of services is the basis for care in Britain, Norway and Sweden. In each of these countries, the local authorities (counties and municipalities) are permitted to shape their own programs based upon local needs. The central government in England provides only broad guidelines for service delivery which identify the floor of services that must be made available. Within these guidelines, local governments enjoy substantial latitude in the design and implementation of their programs. This is intended to encourage local innovation and community initiative.

In Norway and Sweden the central governments similarly produce operational guidelines and quality standards for home care services, but again, municipalities are not required to follow them to the letter. However, as in the case of Sweden, if a municipality wishes to qualify for block grants to subsidize about one-third of the program costs, it will conform to existing guidelines.

The Netherlands, unlike the other countries, provides home care through two voluntary associations, one of which covers home help and the other home nursing. However, because the central government is the primary payor of these services, it has a say in how they are organized. This intervention notwithstanding, local services retain a broad scope in their initiatives.

Although many models of home care programs exist, the emerging, predominant model, at least in the Netherlands, England and the two Scandinavian countries, appears to be a decentralized one with services designed, administered and delivered through local or municipal offices. Responsibility for the overall program generally rests with a regional or district supervisor.

These regional or local offices formulate their own objectives and plans for services within the context of broad national guidelines. The advantages of a decentralized model are that it fosters the search for more creative solutions, it facilitates closer interaction between home care workers and the community, and it makes services more responsive to local needs. The disadvantage of a decentralized model is that it becomes more difficult to coordinate with other services administered at a county or higher level. It also makes it harder to insure adherence to uniform quality of care standards.

Coverage

Coverage for home care was found to be universal in all the countries examined. All elderly assessed to need services are entitled to receive them almost without income restrictions. There are no charges in countries like Argentina and Canada where services are offered as entitlements under their national health care programs. There are charges for home help services but not for home health care in Sweden, Norway and England. Charges for the former are applied on a sliding scale, based on the individual users’ income. Annual fees to the “Cross” societies in Holland entitle clients to home health care.

The limitations which may occur are usually due to inadequate personnel to meet the demands of the target population. There are usually no restrictions on the length of service, and once it is initiated it may continue indefinitely. However, there may be ceilings or limits on the number of hours of assistance per day or per week. In Manitoba, with few exceptions, home care is only provided to the point where costs do not exceed that for institutional care. On the other hand, many programs will set aside these restrictions given their emphasis on providing whatever assistance is necessary to maintain the older person in the community. Thus, in parts of the Netherlands, Norway and Sweden, 24-hour home care is available as a true alternative to nursing homes. This type of coverage truly provides the elderly with effective options in long-term care.

In Norway, 10.6% of the population between the ages of 67 and 79, and 26.9% of those over 80 years received care services in 1986. In the Netherlands, 16% of those over 85 received home help and 7.6% received home nursing in 1985.

In Sweden approximately 18% of the population over 65 receive some home care services with great variations in coverage depending on where the person lives. Thus, service coverage may range from 17% of those 80 or older to over 80% of this age group. The proportion of elderly receiving