

June 1990

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### Recommended Citation

Boise, Linda (1990) "The Demise of the Catastrophic Coverage Act: A Reflection of the Inability of Congress to Respond to Changing Needs of the Elderly and their Families," *The Journal of Sociology & Social Welfare*: Vol. 17: Iss. 2, Article 9.

DOI: <https://doi.org/10.15453/0191-5096.1942>

Available at: <https://scholarworks.wmich.edu/jssw/vol17/iss2/9>

# The Demise of the Catastrophic Coverage Act: A Reflection of the Inability of Congress to Respond to Changing Needs of the Elderly and their Families

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*This paper considers the recent demise of the Medicare Catastrophic Coverage Act of 1988 in the context of the needs of the elderly and their families. Although the surtax imposed on middle and upper income elderly was the ostensible reason for the anger this Act generated among the elderly, other factors related to the concerns and needs of the elderly and of their families also prevented it from being supported. This article discusses the characteristics of the Catastrophic Coverage Act as a continuation of the historical bias of Medicare in favor of acute medical care and as an effort by Congress to restrain federal health care costs. Despite shifting socio-demographic realities which have increased the burden for many families of the elderly, the Catastrophic Act did little to meet their needs. The implications for future legislation to address these problems are also discussed.*

The passage of the Catastrophic Coverage Act of 1988 (P.L. 100-360) represented the first major expansion of the Medicare program since its inception in 1965. Although it overwhelmingly passed the Congress, only 16 months later, in the fall of 1989, it was repealed by just as great a proportion of legislators as had passed it. Under the program, extended hospital and physician care would have been paid for in full by Medicare after an annual deductible, and other changes would have extended coverage of home health care, skilled nursing care, and outpatient prescription drugs. While this legislation represented a substantial improvement in Medicare coverage, especially for those with serious disability and acute illness, it failed to garner support among a majority of elderly. Ostensibly, the reason was the high surtax imposed on middle and upper income elderly

which would have increased annually up to a maximum of \$2100 for a couple in 1993. However, other factors related to the concerns and needs of the elderly and of their families also prevented this legislation from being supported by the elderly whom it was supposed to help.

The purpose of this article is to consider the passage and ultimate demise of the Catastrophic Coverage Act against the backdrop of changes which have occurred in our social and demographic structure in recent years. The characteristics of the Act are shown to be rooted in historically determined characteristics of Medicare and in a political decision-making process which prevented Congress from redirecting the program towards present-day needs of the elderly and their families. The article also considers prospects for future legislation and recommendations for action.

### The Social and Demographic Context of Health Care for the Elderly

While policy debates focus on the extensive public expenditures for care for the elderly, in fact, most care is provided by family members. Eighty percent of functionally disabled elderly in the U.S. are cared for in the community rather than in nursing homes and three fourths of these are cared for solely by family members and friends (Doty, 1986).

Due to the aging of our population and the increase in chronic illness, an increasing number of people will find themselves in a caregiving role: whereas only 4% of the population in 1900 was over 64, in 1980 that proportion was 11.0%, and it is projected to be 11.7% in the year 2000 (Moroney, 1986). People 65 and older are hospitalized twice as often as the population as a whole and they tend to have chronic illnesses such as arthritis, hypertension, orthopedic impairments, and heart disease, which require constant, long-term and expensive care (U.S. Senate Special Committee on Aging, 1986). Because of advances in medical treatment and technology, the prevalence of chronic illness relative to acute illness has dramatically increased in recent years, especially among the older population (Gruenberg, 1977). Also of significance is the projected dramatic increase in the old-old population, those 85 or older, who have the

highest rate of institutionalization (23.5% compared with 1.4% of those 65–69 (Doty, 1986) and of such debilitating illnesses as Alzheimer's disease (22% of people 80 or older compared with 2% of those in the 65–70 age group (Brody, Lawton, and Leibowitz, 1984)).

Not only are the numbers of elderly in need growing, the costs of care are increasingly being born by the elderly themselves despite the "universal" coverage under Medicare. According to a report by the House Select Committee on Aging, out-of-pocket costs for health care services in 1986 amounted to 15% of the income of the elderly. For the first time this amounts to more than the amount which led to the creation of Medicare in 1965 (*Congressional Quarterly*, May 31, 1986, p. 1228). This is due to increases both in copayments by the elderly under the Medicare program and to what Medicare does not cover. In 1984, for example, 42% of out-of-pocket expenses for health care by the elderly went for nursing home care, which is covered by Medicare only when skilled nursing care is needed and then requires a copayment for days 21 through 100, compared with 6% for hospitals and 21% for physicians (U.S. Senate Special Committee on Aging, 1986, chart 11).

The health care costs considered in these figures do not include costs for home care and housekeeping which are not provided by medical personnel. These are covered, if at all, by Medicaid available only for the poor, by federal Older Americans Act dollars, or by limited and highly variable state funding. Only a small amount of federal funding is available for home care services under the Older Americans Act, a drop in the bucket compared with Medicare: in FY 1988, \$1.6 billion were allocated for the broad range of social services provider under the Older Americans Act, of which \$25 million was targeting specifically for home care services. (This compares with more than \$70 billion budgeted in the Medicare program.) Home care services under this program reaches only those with the most severe needs and for only a few hours per week, and the disjointed funding through separate administrative structures produces a fragmented system which lacks the continuity of care advocated by S. J. Brody (1987).

Family members typically provide a significant amount of nonmedical care for the ill or frail elderly including personal

care, household cleaning, laundry, meal preparation, managing finances, arranging for services, shopping, and transportation (E. M. Brody, 1986). While family caregivers provide care out of love and a sense of family obligation, fulfilling these tasks frequently consumes a great deal of time, takes a tremendous toll in stress, and hampers the ability of caregivers to fulfill commitments to other family members and/or to a paid job. Many researchers have documented the impact of caregiving, such as stress (Cantor, 1983; Chenoweth and Spencer, 1986), fatigue and limited time for relaxation (George and Gwyther, 1986) and loss of productivity in paid employment (Gibeau, Anastas, and Larson, 1986).

Changes in family structure and conditions have also affected the social environment in which family caregiving takes place today. While contact between the elderly and their children has remained relatively constant over the past few decades (Shanas and Sussman, 1981), many more middle-aged people today having living parents. In 1980, 40% of all people in their late 50s had a surviving parent (Schaie and Willis, 1986).

Traditionally, care for the elderly took place within extended families and/or close-knit communities. Women remained in the household providing needed care for ill or disabled family members. Today, family caregivers are still generally women (Stone, Cafferata, and Sangl, 1987), but there is a much smaller ratio of women aged 45-54 to elderly and particularly of single women, who have historically been the most likely caregivers for aging parents (Moroney, 1986). Furthermore, women are increasingly employed and unavailable on a full-time basis to provide family care. In 1980, 60% of women, aged 45-64 were in the paid labor force (Schaie and Willis, 1986), and it is projected that between 1980 and 1995, two-thirds of the growth in the labor force will be women (Fullerton, 1987).

When family members provide care for elderly relatives, it often affects their ability to sustain their job. In a recent survey of informal caregivers, Stone, Cafferata, and Sangl (1987) found that of employed caregivers, 21% worked fewer hours in order to provide care, 29.4% had rearranged their work schedules, and 18.6% took time off from work without pay. This survey also found that twice as many daughters (11.6%) as sons (5.0%) had

quit their jobs to become a caregiver (Stone, Cafferata and Sangl, 1987), supporting the contention of Osterbusch, Keigher, Miller, and Linsk (1987) that family caregiving can have a negative impact on women's goals for career mobility and gender justice. The negative impact of caregiving is especially critical among working class families, in which women are employed out of economic necessity.

Ungerson (1983) points out that the fact that women are generally carers is socially constructed, both by the realities of the labor market and by government policy. The state can make a critical difference for women and other family caregivers and for the elderly through the establishment of an adequate health and home care service system with which caregivers can share the responsibilities and tasks of assisting disabled family members. Moroney (1986) recommends a program of support for family caregivers in which family and the state share responsibility for care for the elderly. The kinds of services that can support family caregivers include care attendants, homemakers, housekeeping services, respite care, adult daycare, counseling and referral support for caregivers, alternative housing arrangements, and direct financial aid for purchasing needed supplies and services. At a hearing in 1987 before the Subcommittee on Health of the House Ways and Means Committee, S. J. Brody (1987) recommended a coordinated system which embraces medical, social and residential arrangements and integrates both formal and informal care. Such an integrated system has the potential to make available to the elderly the full range of needed services in a timely manner and with a maximum of support for family caregivers.

It is against this backdrop of need, social and demographic reality, and recommendations for service arrangements that the recent Medicare amendments should be evaluated.

### The History behind the Medicare Catastrophic Coverage Act of 1988

The signing of the catastrophic care bill in July, 1988, represented the culmination of 18 months of legislative work. Overwhelmingly approved in both houses, it was lauded as a

significant achievement by legislators of diverse political persuasions. While the changes represented significant improvement in coverage for acute illness catastrophes, the "progress" represented by the catastrophic legislation was tempered by losses in Medicare coverage over the previous eight years.

Under the Reagan Administration's philosophy of privatizing social programs and with Federal budget deficit reduction as the driving force behind budget considerations, the Medicare program took a beating like no other federal program. Since Medicare is the second largest federal domestic program after social security and with the concerns about uncontrolled health care costs generally, many legislators viewed Medicare as a comparatively easy target for making sizable cuts in the federal budget. As a major tax program, the Senate Finance Committee and the House Ways and Means Committee have primary jurisdiction over it. While the Senate and House Committees on Aging have responsibility for social service programs for the elderly and have explored a broader range of social and health needs of the elderly, the Senate Finance and House Ways and Means Committees have focused their attention on Medicare as a health program, and, during the 1980s, have used it as a means for achieving their main objective, that of cutting the federal deficit.

The 1982 tax bill, for example, cut projected Medicare spending by 9% (*Congressional Quarterly*, March 5, 1983, p. 456). The enactment in 1983 of the prospective payment system, in which hospitals were paid on the basis of set prices for illnesses, or "diagnosis-related groups", was thought by legislators to be a mechanism to increase efficiency and to save Medicare funds.

In 1985, the passage of Public Law 99-177, the Gramm-Rudman-Hollings plan for reducing the federal deficit put additional pressure on Congress to cut Medicare expenditures. Under this plan, if Congress could not produce annual budgets within strictly limited deficits, automatic across-the-board cuts would go into effect. In this context, the debate over changes in Medicare between 1985 and 1987 took place entirely within the context of the deficit reduction effort. As the *Congressional Quarterly* reported on August 10, 1985, "A centerpiece of congressional deficit-reduction efforts has been proposals to cut spending for Medicare." (p. 1594).

### Catastrophic Health Care

Thus, the climate in which the Catastrophic Health Care amendments were considered was predominated by concern about the federal deficit. The original idea for catastrophic health care came from President Reagan. Although the President's own Secretary of Health and Human Services understood that the major health-related financial catastrophe was not acute care in a hospital but long-term services at home or in a nursing facility (*Congressional Quarterly*, May 31, 1986, p. 1227), the President was apparently seeking a way to restrain federal spending for the elderly. During the debates on the Catastrophic legislation, a number of alternatives were considered for extending Medicare to provide better support for care in the home, but these proposals were resisted by Reagan and other conservatives as being too costly. Against Reagan's threat of veto, the Catastrophic Coverage Act did extend coverage under Medicare for home health services from two to three weeks to six weeks for those who required daily intermittent skilled nursing care, eliminated the requirement that the patient be hospitalized for at least three days prior to receiving care in a skilled nursing facility, and provided limited respite support for family caregivers.

While these were important changes, it should be noted that coverage was limited to those who required skilled nursing care and the Act did not broaden the criteria with respect to the condition of the patient. In the spring of 1987, Senator Bill Bradley introduced S 1076, which would have extended home health care to 60 days for Medicare beneficiaries under the broader definition that their condition restricted them from leaving home without support and would have allowed for coverage of nonskilled care such as meal preparation and bathing.

The strongest push for an alternative, however, came from Representative Claude Pepper (D-Fla.), chairman of the Aging Subcommittee on Health and Long Term Care. Although his committee did not have jurisdiction over Medicare, he challenged and maneuvered to force a floor vote in the House on an expansion of Medicare to cover long-term care for chronically ill or disabled, to be paid for by removing the ceiling on the amount of income subject to payroll taxes for Medicare.



Representative Dan Rostenkowski, D-Ill., chairman of the House Ways and Means Committee, bitterly fought Pepper's interference in the deliberations over Medicare. Despite Pepper's lack of success in convincing Congress to endorse his proposal, legislators nonetheless demonstrated an acute awareness of the merit of his efforts. On June 8, 1988, Representative Pepper was given a resounding ovation just before a motion to consider the bill on the floor of the House was defeated (*Congressional Quarterly*, June 11, 1988, p. 1605).

### How the Characteristics of the Catastrophic Coverage Act Limit Help for the Elderly and their Families

While the Catastrophic health care amendments would have made some modest improvements in home and chronic care, they represented, first and foremost, a strategy to contain costs. Rather than redirecting the Medicare program towards the concerns and needs of the elderly and their families, the amendments were grounded in the continuation of historical assumptions and characteristics of Medicare.

(a) The use of community and home care as a cost-saving device. Early in the 1980s, legislators began to consider home care as a less costly alternative to institutional care. In 1981, Congress approved the Medicaid waiver program in which states could target Medicaid funds to individuals at risk of institutionalization and provide home care services as long as costs remained below the cost of institutional care. In 1985, Senator Orrin Hatch (R-Utah) introduced S 1181 which would have authorized block grants to states for home health services for elderly who would otherwise have to be institutionalized (*Congressional Quarterly*, November 23, 1985, p. 2436). By design, such approaches provide minimal help for individuals who are caring for someone at home and wish to continue to do so. According to one estimate, less than 2% of home care patients are institution-bound (Pilisuk and Parks, 1988).

There has also been a lack of support for home-based care for patients discharged from hospitals earlier as a result of the prospective payment system implemented in 1983. In the first year of its operation, the average hospital stay was reduced from

9.5 to 7.5 days (*Congressional Quarterly*, March 30, 1985, p. 581). Between 1983 and 1986, there was a 37% increase in the number of patients discharged to home care and a reported increase in the severity of illness in patients served by home health agencies (Senate Special Committee on Aging, 1988, p. 11). While there has been an increased demand for home health reimbursement under both Medicare and Medicaid during this period, there has also been an increase of 133% in denials by the Department of Health and Human Services for requests for payment of home health care services due to restrictive interpretations of eligibility (U.S. Senate Special Committee on Aging, 1988, p. 11). While the Catastrophic Act extended the number of days that could be covered it did not broaden the criteria for eligibility or the kinds of services that could be provided.

Additionally, the costs considered in Congressional debates have been projected expenditures out of federal coffers, rather than all costs including those to state governments, for private sources of care, or nonmonetized costs to the family (such as stress, loss of employment, illness resulting from caregiving, etc.). As long as costs are evaluated from the perspective of cost-containment, these additional costs will not even be considered.

Beyond the issue of cost-containment, policy analysts have raised concerns about whether it is appropriate to evaluate long-term care solely from the perspective of cost-effectiveness. Weissert (1985) offers a number of reasons why it is difficult to make community care programs cost-effective. In addition to the fact that there is a large pool of home care users who are not immediately at risk of institutionalization, there is limited evidence that community care reduces admissions to nursing homes or hospitals, community care programs have not been found to be as inexpensive as some had hoped, and limited health status improvement from home care programs has been demonstrated.

Weissert (1985) argues that long-term care should be accepted as a legitimate need in its own right and should be not evaluated solely as a cost-saving mechanism. He also points out that there is inadequate knowledge of the effect of home care programs on family caregivers. It is important to note that many studies of cost-effectiveness have not adequately documented

the total costs and benefits of community care alternatives, especially in terms of costs to family members.

(b) The adherence to a medical model for coverage under the Medicare program despite the fact that gerontologists have long advocated an integrated social and medical program (for example, see S. J. Brody, 1974). This has historically meant that hospitalization was necessary before services in a nursing home would be covered by Medicare, that home care services were available on a short-term basis and were geared to individuals with an acute health episode rather than a chronic condition, and that social services were unavailable under Medicare. The Catastrophic Coverage Act made a modest step toward eliminating some of these barriers to the coverage of chronic care but it essentially held tight to its identity as an acute care program.

The alternative approach to expanding Medicare proposed by Senator Bill Bradley (D-N.J.), S 1076, in which home health care would be extended over a longer period of time and a broader range of services would be covered would have allowed for services to supplement or substitute for care provided by family members. Legislators know that to consider coverage of nonmedical tasks through Medicare opens a Pandora's box of demand. By limiting services to medical care and even more restrictively to acute—and primarily institutional care—the Medicare program has successfully avoided the "risk" of substituting for care provided by family members. Catastrophic medical coverage offered the means to set a strict boundary around the types of services covered.

(c) Limiting eligibility to low-income elderly through the mechanism of means-testing. The Medicare program has been a broad-based social entitlement program, available to virtually all elderly individuals, and with an across-the-board fee structure. In recent years, there have been attempts to introduce means-testing into the Medicare program. It was rumored in 1982, for example, that President Reagan was considering recommending that Medicare be limited only to those with financial need (*Congressional Quarterly*, September 25, 1982, p. 2403).

While support remains strong for maintaining Medicare as a social entitlement program, legislators have utilized a means-testing approach in health care for the elderly by allowing Medi-

caid, the federal-state health-care program for the poor, to be the primary source of federal support for long-term care. Thus, federal support for home health care and for nursing home care has been limited to the poor. (While Medicare covered 2.1% of nursing home care in 1984, Medicaid covered approximately 42% of nursing home bills (U.S. Special Committee on Aging, 1986, p. 28). Some legislators have expressed the position that Medicaid is an inappropriate source for coverage of care for the elderly of the Senate Finance Subcommittee on Health (*Congressional Quarterly*, May 11, 1985), but to date they have been unsuccessful in shifting coverage to Medicare.

One of the positive features on the Catastrophic Coverage Act was the liberalization on the "spend down" provision whereby spouses of individuals who need nursing home care must either pay for the care themselves or "spend down" their assets in order for their spouse to qualify for nursing home coverage under Medicaid. Under the new provisions of the Act, the at-home spouse could retain at least \$786 per month plus \$12,000 in assets (in addition to the couple's home). While this provision was tremendously important in reducing the impoverishment of the spouses of nursing home patients, it continued the essential character of federal support for nursing home care through a means-tested approach.

(d) An either-or system with respect to families and public care. Medicare reductions in hospital and medical services in the years prior to passage of the Catastrophic Coverage Act, without corresponding increases in support for community care, have resulted in a greater burden on families. Glazer (1988) has described this increased burden on families as a work transfer from paid employees, both medical and nonmedical, in institutions to unpaid domestic labor, primarily of women. Under recent Medicare revisions, this work transfer occurs in two ways. First, without adequate support for medical or personal care, families are left to purchase care in the market or to take over such care themselves. This includes such activities as bathing, assisting with toileting, giving medications and other medical procedures. Second, whenever a patient is transferred from an institution to a home care situation, nonmedical tasks, such as food shopping, meal preparation, and housekeeping are

taken up either by the patient herself or by family members. These activities are provided as a matter of course in an institution but are ineligible for Medicare coverage in the home.

While families have a strong commitment to their disabled parents and other elderly relatives (Shanas and Sussman, 1981, E. M. Brody, 1981), they have identified the need for support from formal services, especially in difficult caregiving situations (Horowitz, 1983, Lave, 1985). Except for the limited respite care provision, which restricts respite care to caregivers who live with the care recipient and provides a maximum of three hours of care per day, Medicare has failed to move towards a partnership with family members. Those tasks, which were formerly provided by the institutions in which beneficiaries were cared for, and support for family caregivers have not even been discussed in the debates on Medicare.

(e) The increased privatization of services. Consumers themselves pay over half of nursing home expenses and much of home care costs. Proponents of privatization argue that increased competition in the "free market" results in increased efficiency and stimulates the availability of services. But the health care system is strongly influenced by the vast amount of public funding injected into it. Health care institutions offer services based on their profitability and what is reimbursable under public and private insurance. A report to the U.S. Senate Special Committee on Aging (1986) identified inadequate home care services as "one of the most serious problems in the existing long-term care system." (p. 35) This shortage is surely linked to the inadequate public funding of home care and its acute care bias.

While options are being developed in the private sector for those who can afford to pay for them, as S. J. Brody (1987) points out, it is the government which must make such options available to those who cannot afford private arrangements. Working class families who are ineligible for means-tested services and unable to afford private services face the difficult challenge of piecing together formal and informal care arrangements. It is these families, where women are working primarily out of economic need, who must face the greatest burden of providing care for aging family members, without adequate options for substitute or supplementary care.

### Conclusions

Medicare is unique in the United States in providing universal federal support for health care without regard for income. However, during the 1980s coverage under Medicare has eroded while needs have increased. For eight years prior to the passage of the Catastrophic Coverage Act, the Medicare program was squeezed dry in the midst of federal preoccupation with reducing federal spending. As a result, elders pay a higher proportion of their income for health care than they did in 1965 before Medicare began, hospital patients are discharged earlier and in poorer health than they were previously, and family caregivers receive a minimum of support as they struggle to provide home care for loved ones.

The Catastrophic legislation represented an attempt, though a misguided one, to respond to these deficits of the system of care for the elderly, but it failed to rectify the consequences of these earlier changes in Medicare or to respond to changes in the social and demographic structure of our society.

The anger of the elderly over the surtax must be understood in light of the lack of perceived benefits from the Act. The surtax represented the most significant departure from the basic tenets of the Medicare program by introducing differential payments according to income. A large proportion of elderly, especially middle-income elderly, failed to see sufficient benefit to them from this extra tax. While many older people do fear the financial consequences of a major illness, many have addressed this problem through supplemental insurance policies. For many elderly, the fear of long-term incapacity requiring extensive support in the home or in a nursing home is just as strong as the fear of financial ruin from acute illness. The Catastrophic Coverage Act did little to address this concern.

It is not only the elderly who are concerned about Congress's inability to resolve these problems. Family members, especially women, have been the foundation for community health care systems. Despite the record levels of employment of women and the increased numbers of elderly, who, because of increased longevity, are more frequently burdened with chronic disability, the Federal government has failed to develop programs which support and ease the burden for families. The

impact on families is a major "hidden" cost of the retrenchment of the Medicare program during the 1980s and of the lack of an adequate long-term care system.

Although embarrassment over the Catastrophic Coverage Act fiasco has made Congress shy of taking action any time soon, there will be public pressure in the coming months to deal with these issues. How they are worked out can, in part, be forecast by our observations of the past eight years. The preoccupation at the Federal level with the budget deficit, the locus of responsibility for Medicare within the Congressional committee structure, and the historical dimensions of Medicare constrain the prospects for more enlightened policies within the framework of Medicare.

Unless the philosophy and context of health policymaking for the elderly are changed, the problem of providing adequate health and home care support will continue to be unresolved. Segregated as it is within the Congressional committee structure from other Congressional responsibilities for the elderly and with its identification as a tax program, it is unlikely that there will be a significant shift in the direction of Medicare policy. Any changes will be, at best, incremental. The implications of this political reality are: first, there will be pressure to continue long-term care as a means-tested rather than as a social entitlement program. Second, budget deficit reduction will continue to drive Medicare policy. This means that criteria to ensure that the costs to the Federal government remain below costs previously borne at the federal level will continue in force. Costs to family members will receive low priority and programs to address caregivers' needs will receive minimal attention. Third, it is likely that the issue of filial responsibility will be at the forefront of the debate in the coming months as Congress seeks ways to avoid further programmatic commitments.

Cost-containment is a legitimate policy concern, but it should not be the sole criterion for policy development. An alternative scenario to that just described would be the development of long-term care outside of the Medicare system, maintaining Medicare as an acute care program. Weissert (1985) suggests that a federal long-term care program separate from Medicare should be developed. With the current focus on cost-

containment, it is unlikely that any major new social program will be created. However, the frustration experienced by legislators, senior advocates, and the elderly themselves over the demise of the Catastrophic Coverage Act may add energy to efforts to develop national goals and programs for long-term care rather than attempting further revision of the Medicare program.

Another alternative would be the development of a program directed toward the needs of family members who provide care. Pilisuk and Parks (1988) suggest the need for a national caregivers policy "that complements the caregiving of family members with adequate services and one that does not punish them financially for illness or disability or for the decision to provide needed care in the home." (p. 439) Since women are most affected by this issue and will increasingly be so as the baby boom generation moves into the caregiving years, one might expect women's organizations to be advocating for such a policy. To date, however, women's groups have been noticeably absent from the debate on health care programs for the elderly. This may be due to the lack of recognition of the extent to which social and health policy for the elderly affects women. It may also stem from the fractionated process by which public policies are made.

The consequences of the passage and ultimate demise of the Catastrophic health care amendments can either be tragic in preventing any effective policymaking in the near future to address the health care concerns of the elderly, or they can move policy in a more positive direction. We can either view the Catastrophic Act as a failed effort, representing the inability of our Congressional decision-making process to respond to the needs of the elderly, or we can view the withdrawal of it as an enlightened recognition that the historical tenets of Medicare with respect to long-term and community care are no longer appropriate to our present needs. Which of these interpretations of the policymaking process surrounding the Catastrophic Coverage Act will influence policymaking in the coming months is not clear.

It is to be hoped that Congress will reevaluate its approach to services for the elderly. The demise of the Catastrophic Cov-



erage Act should signal the need to cease responding on an ad hoc basis. Now, as the policymakers regroup, would be a logical time to pull together a coordinated effort to refashion policy in a way which responds to the demographic and social realities of present-day society.

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