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by

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ABSTRACT

AGING: LONG-TERM CARE AND THE FISCAL STATE
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Using a case study of long-term care of the elderly in Michigan, this dissertation examines the explanatory power of theories of political economy in accounting for events in the public sector. The aged raise important sociological questions because their numbers and proportion in the population are increasing, because they are regarded as deserving of public services, and because their terms of existence are set through the political process in return for their non-participation in the labor market. How shall a balance be struck between the diverse needs of the state, the private sector, and citizens, in the assumption of costs for the delivery of services to the aged?

The dissertation draws on demographic and historical data to examine the issue of long-term care for the aged, tracing who is in need of care, and how it is that, nationally as well as in the state of Michigan, we have come to rely so heavily on nursing homes. The movement for alternatives to institutional care for the aged--and research indicating the desirability of this alternative--are also reviewed. The dissertation then turns to theories of the state and state

expenditures to provide a framework for understanding the predominance of nursing home care in spite of the long-recognized movement for alternative in-home and community-based care programs.

The dissertation synthesizes relevant theoretical literature for understanding the nature of state spending for human services. James O'Connor (1973) analyzes three sectors of the American economy: monopoly, state, and competitive. Paul Baran and Paul Sweezy (1966) shed light on the role of state spending as critical to the growth of the economy as a whole and the monopoly sector in particular, while Nicos Poulantzas (1975) explores various ways in which the state unifies, separates, or obscures class struggle. Ernest Mandel (1968) clarifies both the role of the state and of capital in the expanding service sector. Medical economists such as Vicente Navarro (1975, 1977), Marc Renaud (1975) and Sander Kelman (1971) examine the history, role of capital, sectors, and limits of the role of the state in the health care industry--analyses which are suggestive for understanding services to the aged.

The case study involves a market analysis of various types of long-term care available to the aged in Michigan. Using both Michigan-specific data, and comparable national data, the provider and market characteristics of in-home chore services, adult foster care, and nursing homes are examined. Analysis of the market demonstrates that the concept of sectors and of the differential role of the state within

those sectors usefully explains the entrenchment of nursing homes and the slow progress made by the movement for alternatives to nursing home care. Finally, the dissertation discusses possible futures for long-term care of the aged.

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION AND OVERVIEW

Statement of the Problem

In recent years, due to a host of economic and social changes, the aged have become visible as a "social problem." Changes in productive roles, advances in technology, and the effects of mobility and urbanization have netted an increasing proportion of the aged in the population while weakening the traditional private, family, and community structures of support. How public resources are allocated to meet the complex needs of this vulnerable group provides a case study for examining the larger sociological question of the political economy of social welfare.

The subject of this dissertation is a largely unexplored topic in the field of political economy: the social welfare function of the state (public, government) sector of advanced capitalist societies. In particular, this study addresses the relationship of the state sector of the economy to the public services purchased on behalf of its aged citizens, seeking to apply theories of the role of the state to the relatively new phenomenon of a highly developed services sector within the economy. This study

explores the tension between the state's various attempts to establish and maintain social priorities, and the influence of service contractors and market characteristics in the development of these priorities.

This analysis of the social welfare function of the state will be developed through a case study of services to the aging. Specifically, this study will focus on the provision of long-term care (both medical and non-medical) to senior citizens in Michigan who are no longer able to live with complete independence. This study takes as a central focus a current movement among professionals and health care activists to re-direct the primary emphasis of state-funded, long-term care from nursing homes and institutions back to the home and community. This movement is part of a larger trend to de-institutionalization which also involves the fields of mental health treatment and criminal rehabilitation.

Thus, this research can also be seen as a case study of how the political process responds to pressure for social change. The interaction among elected representatives, government agencies, proprietary and non-profit service providers, citizen/consumer groups, and other related interests provides a fascinating example of the potentials and limits to social change through governmental processes in advanced capitalist economies.

Political History

On April 6, 1976, a report was issued to Michigan Governor William G. Milliken by a committee established at

the request of the Executive Office the previous December. The focus of the taskforce was to establish the case for in-home and community based alternatives to institutional care for the aged and disabled. The report was to summarize those services currently available as well as those which needed to be developed, and to examine the regulations, policy, and procedures which were encouraging reliance on privately-operated nursing homes as the only setting for long-term care. "The report is to address a range of options to enable individuals who are able, to remain in their preferred place of residence, normally their own homes" (Milliken, 1976, p. 1-2).

The taskforce report analyzed barriers limiting the development of non-institutional services, as well as offering recommendations for their removal. Because of the complexity of the issues, it was concluded that no major changes could occur without concerted political support, and much of the report was directed at documenting the reasons an alternative policy for the state was worth of backing. Ronald Kivi, Director of Office of Services to the Aging and Chairperson of the taskforce, summarized in his cover letter to Governor Milliken: The initial action required is a clear expression of commitment to proceed in the development of alternative service options" (Kivi, April 1976).

That "clear expression of commitment" was not long in coming. In his letter acknowledging the receipt of the

report, Governor Milliken instructed the Office of Services to the Aging to "work with the concerned agencies on an on-going basis" (Milliken, May 1976) to monitor progress on the recommendations. In addition, he offered consideration for new funding where necessary and established a target to implement a state program of alternative care: "Proposals which call for policy change or impact on future budgets should receive full consideration during the development of the 1977-78 Executive Budget. It is with regard to these items that I expect the proposals to be developed and finalized by September 1, 1976" (Milliken, May 1976).

In Michigan, the Governor has carried his support for in-home and community-based services for those who are able to maintain independent living to the Legislature and the public, as well. In his 1975 State of The State address, Milliken declared:

> Michigan should commit itself to attempting to maintain the independence of its older citizens as long as possible. Some studies indicate that a quarter to one-half of all persons in nursing homes do not require the level of care that is provided, but in many cases the patient can no longer maintain independent life without some assistance. (Milliken, 1975, p. 4)

Each year since, the Governor has reconfirmed this support for home care for seniors through his State of the State messages.

Nor is the experience of Michigan unique in the recent focus placed on the need for alternatives to institutional care for the aged. Proponents of "alternatives"

have amassed a body of research which indicates that personal preference, medical recovery, and cost considerations make home-delivered and community out-patient services far preferable to nursing homes for the aged in need of long-term, non-intensive care. The very language of the debate, however, indicates what a major shift in policy would be involved for such a change in priorities to really occur. The argument being made is simply for alternatives to institutionalization, which still places the institution at the center of the definition.

> . . . it is a tragedy of our times that we as a nation should find ourselves in the position of having to think of home health care for the elderly as an alternative to institutionalization. It only stands to reason that in the natural order of things it should be just the reverse. (Pepper, U.S. House Select Committee on Aging)

Because this movement for in-home and community-based, long-term care touches on a variety of issues including social responsibility to the aging, spiraling medical costs, and the efficient use of tax dollars, it has attracted the attention of a variety of citizen groups, public officials, and business organizations. Indeed, in part because of the periodic publicity of fraud and resident neglect in nursing homes, most public officials maintain at least nominal support for non-institutional care.

In stronger terms than mere political rhetoric, however, a wide variety of policy-makers and service organizations have expressed a new awareness of the problem of over-reliance on institutional care, and a new priority for

in-home services. At the Federal level for the last several years regulations controlling the money granted to state and local governments have required the development of alternate care. Title III of the Older Americans Act states:

> It is the purpose of this title to encourage and assist state and local agencies to . . . (1) secure and maintain maximum independence and dignity in a home environment for older persons capable of self-care with appropriate supportive services; and (2) remove individual and social barriers to economic and personal independence for older persons. (Older Americans Act, 1973)

Title XX of the Social Security Act (1975), while not pertaining exclusively to programs for the aged, establishes Federal goals which state services programs must meet. Among the five Federal goals which programs will be given matching funds for are:

- Achieving or maintaining self-sufficiency, including reduction or prevention of dependence; and
- Preventing or remedying inappropriate institutional care by providing for community-based care, home-based care, or other forms of less-intensive care.

These Federal priorities are therefore reflected throughout state program planning documents which establish the basis for state claims to the Federal funds.

Numerous hearings have been held by the U.S. Senate Special Committee on Aging, and several reports released. A 1976 report charged that Federal health policy was "institutionally biased," depriving "hundreds of thousands

of elderly home care through the encouragement of more expensive nursing home placements."

In its monthly newsletter, Washington Report, the American Public Welfare Association (APWA) analyzed the problems of the long-term care system, observing:

> The mix of public and private programs currently available serves only a small number of the people in need, and of them only a few receive the appropriate amount and level of care. . . . The relatively small institutionalized population is over-served; . . . . Many other people receive no care at all . . . (APWA, 1977)

This report concludes with a call for a "national policy on long-term care that can direct and coordinate sources of funding" (APWA, 1977).

Not to be outdone, professional health care associations have themselves issued policy statements reiterating their support for home health services. The American Hospital Association concedes: "Although the home is not appropriate for all chronically ill patients in all stages of their illness, it can provide a desirable setting for more patients far more often than at present" (Select Committee on Aging News, 1976). And the American Medical Association includes a reference to the traditional service of women in home care in maintaining: "The AMA and its Women's Auxiliary have long promoted the use of effective homemaker-home health aide services" (APWA, 1977).

In Michigan, as well, policies and program statements affirm the existence of a community care system beyond political rhetoric. The 1976-77 Annual Plan of the Michigan

Department of Social Services established a program objective of the "development of more alternatives to institutionalization to provide more appropriate living and care arrangements for clients." In a policy statement distributed to local county workers early in 1977, the Department of Social Services implemented a program of "comprehensive Community Care":

> The priority component and nucleus of the community care system is in-home care and service, given that a person's own home is the setting generally preferred to institutional care and is that setting more conducive to personal and situational independence. (Services Manual Bulletin #5431-77-09)

Taken as a whole, these developments might lead one to conclude that a turn-around of priorities has occurred. Documented federal and state policy coupled with the awareness of both politicians and the professional community of the importance of non-institutional care, would suggest that the issue is being resolved. Indeed, the situation would seem even more positive when taken in the context of the strength of similar movements for de-institutionalization in the fields of mental health treatment and criminal rehabilitation. The importance of the community integrating all of its members and actively participating in their care seems to be a recognized aspect of government policy across program boundaries.

Yet other measures of the success of the alternatives movement present a far less glowing picture. For example, four full years since the completion of the Governor's

Taskforce Report, and in spite of policy statements, field directives, and years of inter-office work groups, the Michigan Department of Social Services is only now (1980) attempting to convene a year-long planning group to propose a conceptual design for a "comprehensive community care system" for adults. This planning effort, supported by borrowed staff (not yet in place half way through the year), has no target date nor funding commitment for implementation once the "conceptual design" is proposed.

Indeed, the inter-office work groups are esentially replications/continuations of the Governor's taskforce membership. Historic issues between aging, welfare, medical services, and social services advocates which lurk behind the taskforce recommendations remain unresolved at the state level. While Office of Services to the Aging convened and set the agenda for the 1976 report, its directive from the Governor to work on an ongoing basis with, and monitor progress of, concerned agencies has resulted in no appreciable improvement in local service delivery in the four years since the "concensus" report was issued.

In addition, the history of funding for existing community care programs must be examined, for program appropriations are the key to whether in-home services have actually grown, and reliance on nursing homes declined. It has been said that "the budget is the skeleton of the state stripped of all misleading ideologies" (Goldscheid,

in Musgrave & Peacock, 1964). In fact, if no funding shift occurs to reflect decreased dependence on nursing homes in relation to home care, can these numerous policy statements be presumed to have meaning?

The major programs for services to the aging in Michigan are outlined in Table 1, along with their funding levels from Fiscal Year 1973-74 to Fiscal Year 1978-79. The programs included in this comparison are the major appropriations available to finance long-term assistance in activities of daily living. They do not include income payments to seniors themselves (although these are sometimes used to purchase care) or basic medical coverage, since these are available in a variety of settings. It also does not include minor programs (such as nutrition programs) which are not available in many geographic areas, or which would not, in themselves, be enough assistance to keep a person out of a nursing home. The programs which are included are: nursing home care, home health services, and home chore services.

Examination of seven years of fiscal data shows that budget priorities have remained practically unchanged in spite of the lip-service being paid to community-based care. Each existing program has grown at approximately the same rate, and while those increases are not insignificant, they reflect little increase in attention to the few existing in-home programs. In addition, there has been no funding available for new in-home or community programs,

Table 1.--Program Expenditures for Three Care Programs Across Fiscal Years

FISCAL YEAR	NURSING CARE	HOME HEALTH CARE	HOME CHORE SERVICES	% OF SPENDING COMMUNITY CARE
1978-79[1]	$280,453,000	$1,966,300	$31,381,500	11.9%
1977-78	244,917,300	1,462,300	24,507,500	10.6
1976-77	223,336,500	892,500	23,604,800	11.0
1975-76[2]	315,109,000	1,155,500	25,272,600	8.4
1974-75	205,588,000	833,010	16,751,000	8.6
1973-74	173,538,000	630,900	13,225,000	8.0

1. Last year for which complete expenditures are available.

2. Fiscal year consists of 15 months.

such as adult day care, transportation, or health screening. Over the past several years, only existing programs have been funded in existing patterns. Further, these figures show that although there is a slight upward trend in the percent spent in community settings, home care is consistently funded at approximately 10% of nursing home care. In fact the difference in actual dollar figures between nursing home appropriations and home care has increased every year from 1973 to the present.

As mentioned earlier, Fiscal Year 1977-78 was targeted by the Governor as the opportunity for considering new funding for community care. Yet appropriations in that or future years reflect no change from previous funding patterns. Indeed, while many proposals have been submitted by various offices, departments, and agencies for program expansion or development, they have all been turned down at various points in the budget process.

Behind the figures in this table lie some of the fundamental complexities and dilemmas involved in the attempt to restructure state priorities. First, nursing home care is reimbursed at a much higher rate than home care on a per capita basis, and attempts to improve standards of care for those who could not be cared for in the community further increase the already high unit cost of services. And, because nursing homes have so many fixed costs (physical plant, staffing) reductions in total population would lead to an even higher per capita cost.

(This situation is similar to that of utility companies which find consumer conservation efforts a justification for a raise in per-unit prices.)

Second, because of the changing population patterns which this thesis will document, it is unlikely that the demand for nursing home beds would decline even if the availability of alternative care was increased. As the senior population increases, so will the number requiring skilled care, even if the actual proportion of the elderly receiving such care declines. As succinctly outlined by the Governor's Taskforce on Alternatives:

> A vicious cycle has arisen, whereby institutions require rapidly increasing amounts of funds and tend to dominate health budgets because of the demand for their service; yet part of the reason for the high demand for their service is that options to institutional care are not adequately funded. (Taskforce Report, 1976, p. 2)

What, then, can account for this discrepancy between the "skeleton of the state" and its "misleading ideologies?" What factors intervene between policy development and program appropriations in the state sector? What factors work to maintain the status quo long after the need for change is recognized and treated as a reality? The purpose of this dissertation is to provide a theoretical framework for understanding this apparent contradiction between official public policy in its verbal form on the one hand, and its operational form--the continued flow of financial support--on the other. The extent to which sociology provides a working understanding of the events

of the public sector and the extent to which existing theory fits the actual case study will be assessed.

Theoretical Framework

Political economists have raised important questions about the nature of the state sector of the economy in advanced capitalism. Advanced capitalism, characterized by an economy which must insure private profit, yet is dependent on extensive government support and limited competition, entails a high level of state sector activity. Yet there are few theories available for analysis of this process.

Karl Marx (1960) saw the state as the mechanism by which the propertied class enforced its authority and maintained its position. For this reason, Engels (1902) writes that the primary purpose of the state is to protect and maintain existing property relations. In Capital, (1967) Marx explores one example of state sector activity (the regulation of the length of the working day), yet no further elaboration of the state per se is undertaken.

More recent authors have carried this conception further, specifying in more detail how the state functions to support propertied relations. James O'Connor (1973) analyzes the functions of the state in two major categories: accumulation (creating the conditions for private capital to prosper) and legitimation (insuring the loyalty of the citizens, especially those displaced by the profit-making economy). O'Connor's work shows that in any given state expenditure, these two functions will be difficult to

separate. Yet, he argues that these two functions are in the long-run contradictory, and have led the state to a point of crisis.

Other writers have focused on more specific aspects that can be seen to fall within O'Connor's large framework. Although writing before O'Connor, Baran & Sweezy (1966) deal primarily with the role of the state in furthering accumulation. Baran and Sweezy elaborate the role of state expenditures in absorbing the surplus which characterizes the capitalist economy in its late stages. They view spending by the state as assisting the profit sector of the economy to operate nearer capacity. Through the use of goods and services which would otherwise not be produced at all, state spending assists the expansion of the economy, rather than draining it of productive capacity (as traditional economic analysis would have it).

Importantly, the role of the state in assuring the conditions for accumulation is often less than obvious. Poulantzas (1975) elaborates on the need for the state as a representative of the capitalist class interest as a whole, above the divisions which may seem to occur between the interests of individual capitalists on any given issue. Mandel (1968) points out that with professional politicians and career government administration, the importance of lobbyists, think-tanks, and foundations as proposers and approvers of social policy is enhanced. The relationship between capital and state does not need to be a matter of

direct intervention, but of ongoing contact and information exchange between regulator and regulated. Indeed, within "the state" there develops a diversity of interests which parallel the range of private interests. Interestingly, this thesis is not dissimilar to that of Max Weber, who studied bureaucracy and the state from a less radical perspective.

In addition to its responsibility for securing the conditions for profitable accumulation, the state functions according to O'Connor to maintain the legitimacy of the social order, especially among the dispossessed. As outlined previously, Nicos Poulantzas addresses the political class struggle, which for him is the representation by the state of the interests of the ruling class as a whole. However, he also contributes considerable detail to the subject of the economic class struggle, or the role of the state in what he terms isolation. That is, in the economic sphere, the common interests of the masses are masked by the state. The ideology of individualism ("one man, one vote," and the "land of opportunity") conceals the common condition of the classes and keeps economic self-interest focused at the individual rather than the social-class level.

While each of these works represent important developments in the theory of political economy, these concepts have also been operationalized through case study. Works such as Gabriel Kolko's (1963) and James Weinstein's (1968)

come closest to analyzing the working relationship of the state to the private sector, looking in detail at patterns of interaction and influence in the development of state policy. These studies considerably expand on the range of interests negotiated within the state dispelling the myth of the state as a monolith while emphasizing the consistency of alliance with capital. Piven and Cloward (1971, 1979) provide outstanding examples of the operational study of the "legitimation function" which is all the more relevant to this dissertation for their emphasis on the response of the state to various social welfare movements.

While these formulations of the functions of the state in advanced capitalist economies provide a useful overall framework for this study, a further question must be asked. What is the theoretical relationship of health and social services as a part of the expanding services sector, to theories of the state in advanced capitalism? In what sense can the health care/services industry be understood to embody the principles of capitalism and the state outlined above?

James O'Connor (1973) conceives of the economy as consisting of three sectors. The monopoly sector is capital intensive, and consists primarily of unionized employees working for large, highly regularized corporations. The competitive sector consists of primarily labor-intensive business, with little unionization. The competitive sector includes small businesses such as restaurants, stores, etc.

The state sector has both monopoly and competitive aspects. When the state contracts for provision of goods and services, it does so primarily with the monopoly sector. Yet its own workforce for directly delivered services resembles the competitive sector.

In a related analysis of the health care industry, Vicente Navarro (1975) characterizes a monopoly sector consisting of, or controlled by, financial institutions such as banks and private insurance companies. While others have argued that within the health industry the equivalent of O'Connor's monopoly sector was based on professional status (Freidson, 1970), Navarro emphasizes that even those with the most status as professionals are only recipients of delegated influence, while the controlling factor remains finance capital. In deed, in the field of long-term care all providers are at low-status levels within the health-care industry, while a wide range of capital investment exists.

Navarro further examines the role of the reproductive institutions of health care: those which control service availability and delivery. Educational institutions, research facilities, foundations, and boards of trustees are shown to have a social composition not unlike the class of the finance sector. For reasons such as these, Navarro concludes that O'Connor's characterization of the relation-ship between the state and the monopoly sector also exists in the health care field. Through use of the example of

national health insurance proposals, Navarro elaborates the interdependence of the state and the health care monopoly sector, showing how proposed policy reflects the input and interests of the financial and insurance industries.

Also applying political economy to the field of health care, Kelman (1971) in an historical analysis, traces the development of modern medicine from a cottage industry to its modern capitalist form. In Kelman's view, the high technology, capital-intensive fields of health care (hospitals, research facilities) parallel O'Connor's characterization of the monopoly sector, while the labor-intensive branches of medical care (i.e., physicians) would be comparable to the competitive sector. Again, this is an interesting contrast to Freidson (1970) who relates the capitalist form to the professional status of the labor, rather than the financial base of the market. Of course, in practice the two are of ten closely related.

In an analysis which more specifically addresses the relationship of the state to the health field, Marc Renaud (1975) draws a parallel between the overall emphasis on production/consumption, and the forms of health care delivery of capitalist economies. While he views most major health problems as social problems arising from our economic organization, he argues that state intervention is limited to subsidizing further consumption of health remedies, rather than addressing those causes. In Renaud's analysis, the role of the state in providing health care

serves a legitimation function for the general public, while simultaneously fostering accumulation through subsidizing the commodity/consumption approach to health care.

Based on these and other theoretical works which will be examined in detail in Chapter 4, this dissertation will attempt to shed further theoretical light on the complicated relationship between the diverse needs of both the state and the services sector. The interest of capital in the services sector will be explored, as well as the diversity of economic organization within the range of long-term care services. In the process of accomplishing the state's function of legitimation, through the expanding services sector, how is the twin goal of accumulation also advanced? The theoretical base provided by O'Connor, Mandel and Navarro will help to identify the "monopoly sector" of long-term care, while the case study of long-term care will help to assess the operational adequacy of existing theoretical foundations for a political/economic analysis.

Design and Methodology

This is a case study of the long-term care industry for the elderly, focusing on three separate markets: nursing homes, adult foster care, and home chore services. Data and analysis center on the organization of providers (individual, non-profit, proprietary) and their market conditions set by the state (rate and method of reimbursement, regulation and licensing requirements for entry into the market, and amount of organized participation in the regulation and rate-setting

process). How the state manages the tension between its functions of accumulation and legitimation, and the consequences for each provider, will frame this analysis.

The data used as a basis for this analysis comes from a variety of sources. For the past five years, I have worked full-time for the Michigan Department of Social Services, first in the Research & Evaluation Division, and more recently in the Budget Division, as the senior analyst in the field of services for the aged and disabled. This opportunity to participate first-hand in the policy-making process has been especially valuable in the development of this analysis, and in my observations of how sociological theory applies to contemporary developments in the public sector. In addition, my access to data (which is all considered "public information," although much of it is not in published form) has been considerably enhanced by my knowledge of its sources and locations, as well as my own responsibility for much of its collection and analysis.

Documentation of rate setting/reimbursement policy comes from minutes, reports, and policy manuals from the Michigan Department of Social Services. Information on the larger budgetary priorities and federal policies comes from public documents such as administrative rules and regulations, appropriations bills, legislative acts, and statements, reports, and memoranda of policy makers, analysts, and program administrators. Data establishing the characteristics of provider markets comes from existing surveys and computer

data bases, and other analyses conducted in Michigan and across the country, done under both public and private auspices. The Bibliography contains a separate listing of data sources.

Thus, existing sources of information will be analyzed in order to determine whether theory in the field of political economy can provide a reasonable explanation for the continued strength of the nursing home industry in spite of the apparent support over the last several years for community-based care for the aged.

Organization of the Dissertation

The dissertation begins by setting the background and parameters of the subject. The first chapter presents a social and demographic profile of the aged, highlighting changes in the population over time and the importance of this emerging field of study for sociologists. The second chapter provides a historical sketch of the long-term care industry, documenting the social patterns of care for the frail which have led to the dominance of nursing home and institutional care. It also includes a review of research on the movement for alternative care--findings about the typical range and types of care needs of seniors, studies of the level of services provided and used in nursing homes, comparative studies of the effectiveness of inpatient vs. community-based care, and attempts to qualify cost-benefit analysis of various care settings.

With that groundwork in place, the fourth chapter explores the theoretical foundations of the dissertation, emphasizing the nature of the state welfare function. Theoretical works from political economy and medical economics provide insight into the contradiction mentioned above between established public policy, and the actual flow of funding and availability of care.

Chapter five assesses the explanatory power of this body of theory through case analyses of three provider markets in the long-term care industry, including nursing homes, and two non-institutional settings--adult foster care and in-home chore services. Data are provided concerning the characteristics of each market, and the state's function in establishing and maintaining those characteristics. The analysis emphasizes the role of investors; the method, amount, and basis of state reimbursement; and the type, amount, and level of influence of provider organizations in state legislative or administrative decisions.

The conclusion summarizes the implications of the case analyses for the literature on political economy. To what extent are the ideas of O'Connor, Mandel, Navarro, et al., supported, refuted, or expanded? The implications of this research for understanding the services sector and the state are reviewed, as well as areas deserving further study. Finally, the prospects for the movement for alternatives to institutional care will be evaluated, with an analysis of the likely directions of the movement, given the theoretical understanding acquired through this research.

CHAPTER II

THE PROBLEM OF THE AGING: THE SOCIOLOGICAL AND DEMOGRAPHIC DIMENSIONS

The importance of aging as an issue of social policy compelling the attention of sociologists, lies in the relationship of senior citizens to the rest of society, and the degree to which important social developments are reflected in a study of aging. The "problem" of aging in our society is first and foremost a consequence of another sociological question: the impact of science and technology on social policy. Improvements in medical technology, while providing the immediate social benefit of "long life," have also created a whole host of new social problems (Blau, 1973, p. 4). Lives which formerly would have been lost through accidents, strokes, and other disabling diseases are now being saved. People are living to be older, yet surviving with greater disabilities than ever before.

> It is particularly frustrating irony that progress in man's search for a longer life should produce the "problems" of aging. In fact, the very successes in economic, medical, and industrial "progress" that now permit such a large proportion of our population to reach old age also have produced the changes that made the elderly a generally

> dependent group and have robbed them of their most important traditional functions, roles, and statuses. (Brotman, 1974, p. 249)

How to improve the quality of these added years is a question that technology cannot answer. Thus, in a larger sense, issues of policy for the aged are issues of how society will cope with the impact of its own advances.

Second, the aged are a group marginal to the economy. Mandatory retirement, like schooling for youth and hard-core unemployment, helps to define the eligible working population within limits the private sector can profitably absorb. While in 1900, 66% of the elderly were employed, now only one in four are employed (Population Bulletin, p. 12). This figure is even further reduced beyond age 70, since more than half of all the aged who do work are between the ages of 65 and 69 (U.S. Bureau of the Census, 1974, p. 24). Seniors today are among those whose existence is primarily assured by the economic insurance provided by society in exchange for exclusion from "productive" roles. Thus the study of the aged presents useful insights into an aspect of the economy which is otherwise hidden and difficult to document: those whose incomes are politically managed in return for non-participation in the labor force.

Third, and as a result of a declining birth rate as well as an increasing life expectancy, the aged represent an increasingly large proportion of the United States population. This increasing percentage of people excluded from contributing to the economy, yet with a unique set of needs for health and

social services, has important consequences for the state sector of the economy. While in 1900, seniors were 4.1% of the population, in 1970 they were 9.9% (U.S. Department of Health, Education & Welfare, 1973). This more than doubling of the proportion of aged, coupled with the reduction of seniors employed, places great strain on the programs of support financed from taxes on the (proportionally reduced) workers. This aspect of the fiscal crisis is not projected to lessen: It is estimated that by the year 2,000, older citizens will comprise 11% of the population (Brotman, p. 250). While in the future the demands for publicly supported incomes may be offset by more workers being covered by private pension plans, the trend toward earlier retirement, especially in times of high unemployment, may further reduce the proportion of economically active (i.e., tax revenue generating) people. Here, the tension between the needs of the private sector (a restricted labor force, but publically financed unemployment and pensions) and the needs of the state (an expanded wage base for taxation to fund such demands) is especially clear.

Finally, the situation of the aged in our society is a case study of changes in family relationships due to urbanization and generational mobility. With demands of the workplace encouraging smaller, more independent family units, many aged parents live great distances from their children--who may have long-established independent households before their parents are of an age to need assistance.

In addition, the changes in production which sparked that mobility have also changed the power and status of seniors in their families.

> The rural multigenerational family has been supplanted by the urban nuclear family, with the elderly living in separate households and without their former roles in family life. The individually owned family farm or craft shop, where the older head of the family owned the "wealth" and the means of production, has been replaced by corporate ownership and a wage economy in crowded urban settings. (Brotman, p. 249)

Many of the elderly who moved to the cities in earlier migrations, are now living alone in inner-city older homes which they cannot afford to sell. Their children, on the other hand, have been a part of the more recent suburbanization. Over 60% of the population currently lives in metropolitan areas, yet most of the elderly live in the central city while most of the youth live in the suburbs (Brotman, p. 251). The aged, without the traditional support structures of family and community, must more often turn to government sources when the need for assistance arises.

Profile of the Aged

What, then, does it mean to be aged? What are the characteristics of a "typical" senior citizen? Such a profile helps one better grasp the dimensions of the public policy issues which are involved. Yet an important note of caution must be entered. There is nothing magical about the passing of a particular birthday which changes one to "aged." At all ages, people are sick or healthy, wealthy

or poor, working or unemployed. The retirement age itself is socially defined, and varies by industry, seniority, and country.

In this sense, probably the most remarkable feature of the aged is their diversity. The 30-year span between ages 65 and 95 brings innumerable changes in physical and social circumstances. Considering the differences which occur essentially between two genrations (the "young aged" and the "older aged"), it is to some extent futile and misleading to attempt to summarize that diversity into a single set of figures. Yet because of their relationship to the economy and to their families/communities, the aged do share important distinctions from the rest of society. It is to better understand these aspects of aging that the profile below is presented.

Life Expectancy

The average life expectance at the turn of the century was 43 years. Today the life expectancy at birth is 71 years. Table 2 displays the increase in life expectancy since 1900.

However, these figures, which show remarkable advances in the life-span, do not mean that older people are living longer. Rather, they represent large gains made in infancy and childhood mortality, in the number of people living to be old as opposed to how old the elderly are.

Table 2.--Average Life Expectancy at Birth

(Source: Bureau of the Census Current Population Reports)

> To a large extent these dramatic gains are due to a sharp decline in infant and child mortality rates, age categories in which death rates were normally highest in pre-modern societies. In the United States, for example, the sharpest decline in the death rate has occurred in the one-to-four age group; a more moderate decline has occurred among the five-to-fifty-five age group, and the smallest decline is found in the age group beyond fifty-five. (Blau, p. 4)

In spite of this, the median age of those over age 65 is also continuing to rise. It is now at 73 years of age. For those who have reached age 65, the life expectancy is an additional 15 years (U.S. Department of Health, Education & Welfare). Among the aged, it is the oldest part of the population that is growing fastest. Forty percent of those over age 64 are also over age 75 (Brotman, p. 250).

It is estimated that by 1990 approximately 20% of the aged will be over 80 years of age (Population Bulletin, p. 11). This rising proportion of the elderly in the highest age brackets is usually attributed to the cohort effect of the high birth and immigration rates for those born around the turn of the century.

Sex Ratio

The life expectancy for women exceeds that of men at all ages. In 1970, at birth the life expectancy for women was 74.8 years; for men it was 67.1. Part of this difference is attributable to the higher death rates of men at younger ages, for the gap in life expectancy is narrower. For those reaching age 65, men can look forward to an additional 13.1 years; women to 17.0 (National Center for Health Statistics). Thus the 8-year gap between women and men at birth is halved by age 65.

The gap between life expectancy for men and women, however, continues to grow. While in 1920 the difference between women and men was 1.9 years, in 1970 the gap had expanded to 7.7 years. The difference is equally pronounced at age 65. In 1920, women outlived men by .6 years. In 1970, the average life expectancy for women was four years longer than for men (National Center for Health Statistics).

The result of this differential in life expectancy is a high proportion of women among the aged. While the

general population is 51% female, the age group 65 or over is 58% female. Beyond age 75, the proportion of women rises to 62% (Brotman, p. 20). This disparity is increasing over time. In fact, in 1900, men over age 65 outnumbered women, while by 1970 there were 72 men per 100 women. By 1990, this is projected to decrease to a ratio of 67.5:100 (Population Bulletin, p. 9).

The social consequences of this sex ratio are compounded by the custom of men marrying women younger than themselves. Most aged men (78%) are therefore married; most aged women are widowed or single (62%). Since women, particularly of earlier generations, have had less access to education and employment, this high proportion of women (especially widows) goes hand in hand with their higher poverty rate and lack of traditional supportive institutions.

Chronic Disease

While advances have been made in the science of acute disease, chronic disease remains a factor in the lives of most senior citizens. Approximately 80% of the 65+ age group have one or more chronic conditions (O'Brien, p. 5; Birchenall, p. 7), with arthritis being by far the most frequent problem. The incidence of chronic disease increases dramatically with age. While at middle age, 66% of people report a chronic condition, by age 80, most people have at least three such disorders (O'Brien, p. 5).

The implications of chronic disease for the daily life of an aged person vary considerably. While 20% of those in

middle age report some limitation of activity due to chronic disease, 40% of those age 65+ make a similar complaint (National Center for Health Statistics, and Birchenall, p. 7). Fifteen percent of the aged are unable to carry on their major daily activity (work, housekeeping, etc.) due to a chronic condition (Riley & Foner, p. 214).

The importance of chronic disease for the aged cannot be overstated: It has emerged as the major cause of death. Heart disease, cancer, and stroke account for 83% of deaths among the aged (Table 3). Progress in finding solutions to these diseases which cripple and kill is much slower than for infant and young adult diseases.

Table 3.--Major Causes of Death in 1972 for Persons 65+

Rank	Cause of Death	Percent of Deaths
1	Heart Disease	49.7
2	Cancer	17.6
3	Stroke	15.7
4	Influenza/Pneumonia	3.8
5	Arteriosclerosis	2.7
6	Accidents	2.5
7	Diabetes	2.4
8	Respiratory Diseases	1.9

(Source: U.S. Department of Health, Education, & Welfare, National Center for Health Statistics P 23, No. 57, p. 49)

Income and Poverty

In 1971, the median income of older couples was about $95 a week, and of older individuals, $45 a week (Brotman, p. 251). This represents an annual income of $4,940 or $2,340, respectively.

Shown as a distribution, these 1971 income data reveal that the range of incomes among couples is much greater than for individuals (who are disproportionately lower-income, widowed women):

Table 4.--Percentage Distribution of 1971 Income for Elderly Couples and Individuals

Income	Couples	Individuals
Less than $1,000	01%	10%
$1,000 to $3,000	20	59
$3,000 to $5,000	30	18
$5,000 to $10,000	32	13
$10,000 or more	17	

(Source: U.S. Department of HEW, Administration on Aging, "New Facts about Older Americans," 1973)

Thus, while some elderly are able to live quite comfortably, 20% of the couples, and nearly 70% of the individuals are living on $58 per week or less. Fully one quarter of aged individuals have incomes of under $1,500.

These income differences are even more pronounced if one examines sex and age breakdowns among the aged. As Table 4 indicates, men withstand a considerable income reduction in the retirement years; the income reduction for women is less pronounced due to its already low level. While income for blacks is considerably less than its white counterpart, men of either race report more income than women.

Table 5.--1973 Median Income by Age, Sex, and Race

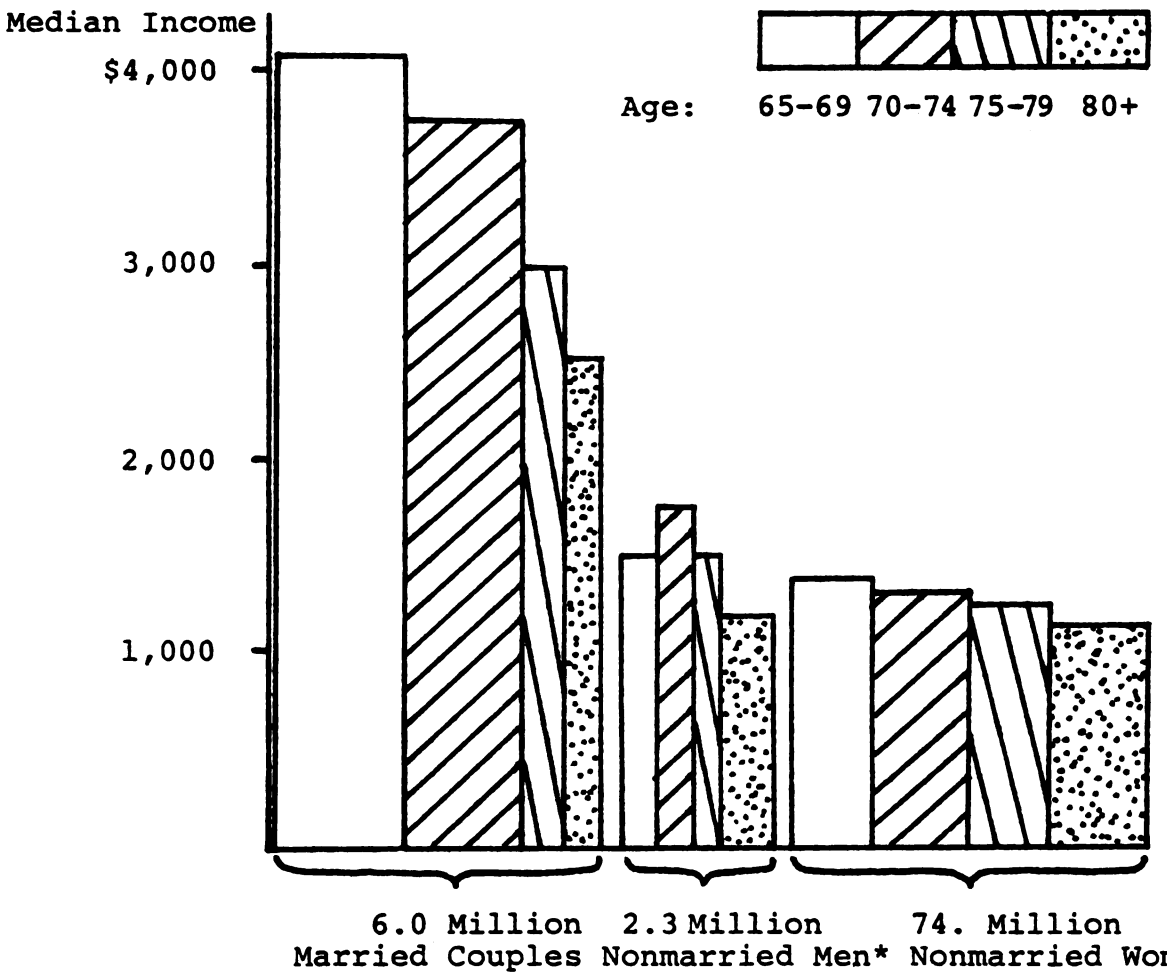
	Men		Women	
	55-64	65+	55-64	65+
All	$9,552	$4,106	$3,431	$2,119
White	9,989	4,317	3,641	2,192
Black	5,294	2,281	2,109	1,519

(Source: U.S. Bureau of the Census: P-23, No. 57, p. 32)

Throughout the retirement years, income steadily declines. In part this reflects the fact that among the current aged, pension programs were begun in time to benefit some of the "young" aged, but fewer of the older aged. However, it also indicates the erosion of resources over time of those out of productive roles for a number of years. Table 6 presents the median income, by age, for couples and

individuals. The bars are proportional in size to the percentage of the total population age 65+.

Table 6.--Median Income, by Age, of Couples and Individuals Age 65+



*Includes divorced, widows, never married.

(Source: Birchenall, p. 5)

While the aged represent 10% of the United States population, they account for 20% of those living below established poverty levels (Brotman, p. 251). Indeed, one-quarter of the aged are poor (Brotman, p. 257; Birchenall, p. 6; O'Brien, p. 8). As indicated earlier by income level, the incidence of poverty among the aged is much higher for single people, especially women. Fourteen percent of elderly couples are below the poverty threshold, and half of the individual seniors (Population Bulletin, p. 15). Women compose 65% of the aged poor, and most of these women are in the category of "individuals" (Brotman, p. 251).

Living Arrangements

Most senior citizens (age 65+) live in family settings--an average of about 62%. One-third live alone, while between 4 and 5% live in institutions. There are, however, large differences between men and women, as indicated in Table 7.

These differences by sex can be explained in part by the effect of marital status, and in part by the effect of age. Seventy-eight percent of elderly men are married, and living in family settings. The corresponding figure for women is only 38%. Not only are women more often widowed or alone (there are more than four times as many widows as widowers); women tend to be among the older aged. Age itself is a major factor in decreasing independent living. Among those over-80, the incidence of

Table 7.--Percent of Elderly in Various Living Arrangements, 1970

Living Arrangement	Men	Women
Family	79%	59%
Alone or with a nonrelative	17	37
Institution	4	4
Total	100%	100%

(Source: Population Bulletin, p. 16)

institutionalization approaches 20%, yet the proportion of men who live independently is still more than twice that for women (presumably because of the existence of a younger wife to provide any care needed). (Sourander, p. 15).

Thus there is wide variety in the living arrangements of the elderly. There are many relevant factors influencing where a senior will live: income, age, sex, marital status, physical health, etc. It is here that the diversity of resources and need of those over age 65 is most directly visible.

Analysis of Profile

The profile just drawn shows an aged population which is increasing due to declining death rates in the earliest years, and growing fastest in its oldest age brackets. The imbalance in the proportion of senior men and women is increasing, while traditional supportive resources in

families and communities are decreasing. Poverty and disability due to chronic disease are not uncommon life circumstances. Thus not only is the elderly population growing, but it is growing fastest in its most vulnerable segments: those over age 75, who are most likely to be widows, poor, and suffering with chronic disease. Indeed, the composite view of this profile leads clearly to the notion now gaining concurrence, of poverty and aging as feminist issues (Riddiough, 1981).[1]

The significance of these data lies in their implications for increased demand on state sector services, and the willingness and ability of the economically productive to support them. From a demographic and social policy point of view, the crucial question must be whether the economy can maintain a ratio of productive (i.e., in the wage labor force) citizens to dependents (children, aged, or disabled) sufficient to fund through taxes the services demanded of the government. There must be enough workers to create enough surplus over time to cover the expenses funded by the state for those not included in productive activity.

Analysis and projections of the worker:dependent ratio have shown that if birth rates continue to remain low, the overall ratio will not drop significantly below its current level. That is, each worker in the future may be supporting fewer children, but more seniors. Even assuming that a low birth rate will hold the worker:dependent ratio constant, there are difficulties ahead in funding services for the elderly.

The types of services needed by the aged are both expensive and underdeveloped. In addition to the general needs for income support for basic food, housing, and clothing there are needs for acute, chronic, and intensive health care; various forms of sheltered housing from seniors apartments to nursing homes; and services such as meals/nutrition programs, day care, and transportation. Thus, even a stable ratio of productive citizens may not prove adequate to meet the need, since the per capita cost of those services is increasing and may be higher than the per capita costs of the children's services they are replacing.

Further complicating the adequacy of the productive: dependent ratio in meeting the future needs of seniors is the fact that the current ratio and delivery mechanisms may be inadequate. That is, many would argue that children's programs themselves are not adequate (i.e., day care), and a dollar for dollar shift of priorities following population trends would hardly be likely or appropriate. Thus the question for the future is how both existing services and these new and growing citizen needs will be met.

The current approach, and the one which seems most likely in the immediate future, is continued strain and compromise within existing funding sources. Perhaps the most prominent example of this approach can be seen in the current debate over funding for Social Security. At the time that it was begun, Social Security was intended to

ease unemployment among younger workers by making it possible for older workers to retire. At that time there were 10 workers who (with their employers) were taxed, for each beneficiary. Changes in population trends as well as eligibility have reduced the worker:beneficiary level to 3:1. At the same time, increases in the life expectance and the trend to early retirement at age 62 have raised the number of years a person is likely to draw on the system. And, in recent years the increased benefit levels and automatic cost of living adjustments coupled with high unemployment have severely altered the income and claims picture for Social Security (Dershick, 1979).

Many solutions have been proposed to stabilize the Social Security fund. Each is controversial, because it calls into question some aspect of the existing precarious balance between workers, dependents, the needs of employers, and government. For workers, proposals include both increasing the rate of tax, and the maximum taxable income. This causes the young, current payees to question whether their future benefits will ever return the extent of their investment, and highlights the still-regressive nature of Social Security financing.

For employers, it has been suggested that there be no salary maximum, so that employers would pay their rate of tax on the full amount of the employee's salary. However, both business and labor agree that the "employer's share" is funded either directly through trade-offs in other worker

benefits, or indirectly through increased prices to the consumer. Thus, the long-term effect of such a change would be to maintain the system of a within-the-working-class transfer program.

A third proposal for Social Security would be to eliminate the payroll tax for Social Security, and fund it directly from general tax revenues. This proposal is controversial because it strips Social Security of the "insurance program" aura which has been its source of legitimation. But since the reality is that workers are not each paying into a trust fund for their own future, but paying for the benefits drawn by current recipients, use of the General Fund would recognize the real cost to all of society for the care of its aged members. Since the tax mix which builds the General Fund includes taxes on income above the Social Security maximum as well as corporate and other taxes, it would be somewhat less regressive than the existing approach. Even this proposal, however, does no more than modify existing funding sources, attempting to handle increasing costs by re-dividing the tax revenue pie.

Other possible solutions to the worker:dependent funding problem can be envisioned which would involve changes in our current social definitions. Since the setting of a retirement age is arbitrary at best, strain on the worker:dependent ratio could be met by social redefinition of the productive years. This could occur at either end of the age spectrum through employing youth at a younger

age (redefining an "adequate education"), or through raising the retirement age. In many western European countries, for example, the retirement age is 70.[2]

Interestingly, however, the effectiveness of this method of relieving the state sector financial crisis is directly at odds with other aspects of the economy. The very reason for the artificial limitation of the employment pool by mandatory retirement is the inability of the profit-making economy to provide enough jobs. Thus while the state needs to expand its tax base through more employment in order to fund those services needed by the dependent, the private sector is attempting to cut costs by keeping the workforce as small as possible.

Other types of social redefinition could include a change in family structure to absorb the aged into the productive households of their children. In previous generations, families consisted of more children who lived at home longer, and parents did not have as long a life-expectancy. Kinship networks existed within the community, and it could even be the case that the youngest child was still in the home as the parents became more dependent from age. In this relationship, with the aged parents able to retain their home, some authority and status remain with the aged as members of a family and community.

This would be significantly changed in a "new" extended family which would be formed by aged members divesting themselves of homes and life possessions to move into a child's

already-established household. And again, this type of redefinition which would solve funding problems for the state, would stand in sharp contrast to the economic need for mobile, small, high-consumption family units which have become the majority pattern.

For all these reasons, the field of aging is an especially timely case study for understanding the nature of the political economy, and for monitoring the "fiscal crisis" resulting from the legitimation and accumulation functions which must be performed by the state. The tensions generated by changing demographic patterns may force the system of state capitalism (public sector support and guarantee of private profit) to evolve toward state socialism (government management of public services). Because the aged are considered to be among the most legitimate of the dependent classes, it is in the field of services to the aging that these changes can first be observed, monitored, and studied.

CHAPTER III

HISTORIC AND RESEARCH DIMENSIONS

Historical Background

How have we as a society come to the state of affairs where a costly type of care is the major choice available to the aged, in spite of the fact that few of the aged desire or need this intensive level of care? In this chapter both the history of care for the aged, and the research evidence on the types and amounts of care needed by the aged will be reviewed.

> The nursing home as a money-making enterprise is quite new in America. As recently as the 1930's there were only a handful of nursing homes in this country, and those few were mostly of the mom-and-pop type that is now disappearing. Larger homes were usually run on a non-profit basis by a church or fraternal order as a service for their membership, or by local government as a "poor folks home" . . . . (Mendelson, 1975, p. 34)

The current reliance on nursing homes for the care of the aged is a relatively new development when viewed historically. The roots of civic supported care for the chronically ill and aged can be traced to 17th and 18th century British traditions, yet nursing homes were virtually unknown before 1930.

Care for the aged, until recent times, was not distinguished from care for the poor in general, or from

those at any age with chronic physical and mental illnesses which prevented participation in the mainstream of society. The British Poor Law of 1601 formalized the responsibility of each parish to provide for its own poor through "outdoor relief"--support of individuals in their homes.

As the size of the welfare population grew beyond parish capabilities and the Puritan ethic turned public attitude against outdoor relief, the almshouse, or workhouse became the solution to the problem of dependent populations. "Indoor relief," which removed the poor from their homes and provided bed and board in exchange for labor, was designed to be degrading enough that no one would be needlessly dependent. "Only those in most desperate need would accept the restrictions and humiliations entailed in such institutionalization" (Freymann, p. 28).

While such programs were intended for the able poor, they also became the shelter for the mentally and physically infirm of all ages, as well as for orphans and foundlings. Infirmaries, or "lying-in-wards" became a part of the workhouse. Characterized by a lack of medical staff, supplies, or sanitation, these wards became "sinkholes where the insane, the aged, the destitute, and the dying were mixed indiscriminately with newborn infants, children and even criminals" (Freymann, p. 27).

As the problems of the almshouses increased, especially crowding and the spread of communicable diseases, an

evolution occurred through the 19th century which effectively dismantled the heterogeneous population in indoor relief. This trend was the gradual splitting of the almshouse population into separate facilities for the mentally retarded and mentally ill, and the development of public hospitals to care for the acute illnesses of the poor. These public hospitals (second-class citizens to the "voluntary" or private hospitals for paying patrons) followed the direction of their private counterparts, specializing in the treatment of medically "interesting" acute diseases (fitting with their simultaneous function as a training facility for doctors) and shunning the chronically ill or infirm.

By the 20th century, all that remained of the former almshouse population were the aged, infirm, chronically ill, and the poor workers that indoor relief was originally intended to serve.[3] It was not until the advent of the Social Security Act of 1935 that the situation of the aged or the poor in the U.S. changed substantially.

The Social Security Act of 1935 for the first time established a type of old age and disability "pension," which provided a large infusion of funding into the field of care for the aged and disabled. The Social Security Act was patterned after earlier legislation in New York (the 1930 Old Age Security Act), which was a reaction against the discredited indoor relief programs of the day. In an effort to remain independent of the political fall-out over indoor relief, the Old Age Security Act "specifically

excluded state welfare reimbursement for inmates of public and private institutions. Only those . . . not requiring continued institutional care for physical or mental conditions, were eligible for state support" (Freymann, p. 30). While the Social Security Act did not include New York's stipulation against private institutions, (noted for thier more exclusive care) it did retain the exclusion of inmates of public institutions so as not to tarnish the fragile legitimacy of Social Security with any alms house association

The net effect of this regulation was to encourage states to establish private, non-institutional systems of care, since 50% federal reimbursement would be available for this. While records of the time do not show this to be a matter of conscious design, proprietary nursing homes developed quickly in response to a need which could not be met any other way:

> What did happen was the proprietary nursing homes were the only way welfare administrators could evade the law in the face of a legitimate and overwhelming need. The proprietary homes were in a seller's market. It is no wonder that they grew so rapidly. (Freymann, p. 31)

The availability of federal funding for reimbursement, coupled with the demographic trends outlined earlier which greatly expanded the demand for such services, led to an exponential growth in the number of proprietary nursing homes in the following years. It was not until 1950 that Congress changed the regulations to allow for federal reimbursement for care provided in public facilities (other than institutions for tuberculosis and mental disease). Table 8 outlines the growth of proprietary, public, and voluntary nursing homes in New York between 1935 and 1964 as a result of these legislative actions.

Table 8.--Growth of Nursing Homes in New York State, 1935 to 1964

Year	Proprietary			Public			Voluntary			Beds/1000 aged
	Homes	Beds	Increase in Beds (%)	Homes	Beds	Increase in Beds (%)	Homes	Beds	Increase in Beds (%)	
1934	28	441		47	2129		97	3458		7.58
1955	738	18,547	4100	45	5998	184	191	6700	94	20.4
1964	533	24,163	5370	45	9131	332	153	8768	153	22.5

(Source: Thomas, W. C., Jr.: Nursing Homes and Public Policy: Drift and Decisions in New York State (Ithaca: Cornell University Press), 1969, pp. 260-267.

In addition to establishing a mechanism through Social Security for providing income for the aged and disabled (which could be used to purchase care), the federal government also became active in the 1950's in providing funding for the construction of facilities. In 1954, funding became available under the Hill-Burton Act (1946 Hospital Survey & Construction Act) for the construction of public and non-profit nursing homes. Interestingly, then-Secretary of HEW Oveta Culp Hobby argued strongly for this bill in part as a cost-containment measure rather than keeping the chronically ill inappropriately in acute hospitals (Thomas, p. 112). This is the same argument currently being made in favor of in-home rather than nursing home care. By 1959, however, proprietary homes won access to FHA-guaranteed loans for construction, which did not involve many of the requirements applied to non-profit homes under the Hill-Burton Act funding.

At the same time, movement was afoot on the subject of national health insurance. As opposed to the previously mentioned income (Social Security) or facility development (Hill-Burton) programs, health insurance programs would provide financing for the actual cost of medical treatment. Interest in government-financed health insurance was voiced as early as the 1930's in the U.S., in conjunction with initial Social Security legislation. It was not until the late 1940's, however, that this issue gained momentum.

Throughout the Truman years, medical coverage programs had some support from both the executive and legislative branches. Spearheaded by the annual introduction of the Wagner-Murray-Dingell bill in Congress, and Social Security Board officials Wilbur J. Cohen and I. S. Falk, the national health advocates and the American Medical Association were engaged in a deadlocked debate. This debate was further intensified by the 1955 merger of the AFL and the CIO, both active health care lobbys (Townsend, p. 29).

It was not until 1960, however, that any expansion of health coverage was achieved. The passage of the Kerr-Mills Bill expanded the 1950 medical vendors payment program, which provided a Federal match for states reimbursing medical care for recipients of Old Age Assistance and to the "medically indigent"--the forerunner of Medicaid. Although President Kennedy introduced a Medicare bill in 1961, AMA and insurance industry objections to it effectively delayed its passage until 1965, when both Medicare and Medicaid were passed.

Medicare, a program of health insurance for all the aged, was administered by Social Security and included provision for reimbursement for care in an "Extended Care Facility" (ECF) under certain circumstances (100-day maximum, if admitted within two weeks following a three-day hospital stay, etc.). The concept of an "ECF" was based on the model of convalescent care units which existed in a few hospitals at the time, but certainly in

no volume as to represent an actual available resource. In absence of ECF's to authorize for this type of care, Social Security decided to use existing nursing homes instead. Thus, a massive effort was undertaken to certify nursing homes to qualify for Medicare ECF payments. According to Social Security estimates, 2,500 facilities needed to be certified by January 1967, in order to meet anticipated demand, and there were 13,000 nursing homes across the country.

Letters were sent to the 13,000 nursing homes, outlining standards considered minimal for ECF (including 24-hour nursing coverage, personalized care plans, and dietary supervision). Only 740 homes met their basic requirements. In order to meet the estimated need of 2,500 facilities, Social Security then decided to allow certification of nursing homes in categories of "substantial compliance" and "conditional compliance." In addition to the 740 certified homes, 3,210 homes were deemed qualified "substantially" and another 210 "conditionally." There was no target date set for when these homes would be required to improve their ratings, in spite of fire and safety violations allowed even under "substantial compliance." By 1970, the "conditional" label was eliminated, and the "substantial" category came to include all homes with "correctable deficiencies." By June, 1970, the number of fully certified nursing homes had grown to

1,274; yet 3,382 were receiving the same reimbursement under the conditional rating (data from Townsend, p. 43-45).

At the same time, Medicaid was providing reimbursement for the health care costs of all poor (medically indigent) under the direction of the Medical Services Administration (MSA), Department of Health, Education, and Welfare. Medicaid also allowed payment for nursing home care, but removed from the recuperative extended care concept of Medicare. Medicaid reimbursed for maintenance in a nursing home (unlimited length of time) in its own category of nursing home: skilled care facilities. "MSA definition of skilled nursing homes, issued in March 1967, was so minimal there were, in effect, no standards. The rationale was that since Medicaid was to be administered by the states, the states should be responsible for protecting the interests of patients in nursing homes" (Townsend, p. 51). The minimal nature of Medicaid standards can be seen in the provision of funds to 12,000 nursing homes under Medicaid, approximately three times the number certified for Medicare (Townsend, p. 51).

Thus, in 1965 two payment programs were enacted which provided extensive financing and few controls for the care of the aged and indigent in nursing homes. Many of the same homes were eligible for reimbursement from two different sources for different sets of clients, under different standards for facilities and care. The common features of these two programs were the absence of inspection capability,

high standards of care, or enforcement of standards as written. In the year 1969, after four years of start-up time for the regulating agency, only 16 homes participating in Medicare withdrew under compulsion from Social Security (Townsend, p. 44-45).

> According to a statement made by the president of the American College of Nursing Homes Administrators in 1969, officials of the Department of Health, Education and Welfare "have in succession lowered previous standards while at the same time granting generous waivers from the lowered standards and postponing the absolute deadline for meeting those same lowered standards." (Freymann, p. 32)

The net result of the simultaneous enactment of Medicare and Medicaid was a vast increase in the amount of reimbursement available to providers of nursing home care. Because reimbursement was on a "cost-plus" basis (cost plus a return on capital investment), nursing homes became a profitable business, attracting several national hotel chains (Freymann, p. 31). "It was no accident that in the years immediate following passage of Medicare, the hottest of the hot stocks on Wall Street were those of profit-making nursing homes for old people" (Thomas, p. 311).

The passage of Medicare and Medicaid also had an effect on the size and number of nursing homes available to provide care. From 1963 to 1968, the average size of nursing homes more than doubled, from 25 beds to 58, and as of the spring of 1969, 169 new nursing home beds were being licensed each day. These new licensees reflected the change from cottage industry, "under-capitalized and amateurishly administered,"

to the professional business organization of today (Freymann, p. 31-32).

Finally, these programs marked the beginnings of what is developing to be a system with two standards of care. As evidenced by the number of homes receiving Medicaid funding (as opposed to Medicare) and the administrative accommodations made to ensure availability rather than quality of care, receipt of government aid is no guarantee on the standard of care one receives. Indeed, a study done in Minnesota in 1967 found that the major determinant of quality of care in the home was not related to its proprietary or non-profit status (as expected), but rather was inverse to the proportion of welfare clients in the home (Anderson, et al., p. 19).

This finding has since been reconfirmed by studies done in 1972 (Kosberg and Tobin) and 1974 (Barney and Galtesman). While size of home, proprietary non-profit status, and percent of private/public pay clients are all related variables, the proportion of public pay clients bears the strongest relationship quality of care as defined and measured by each of these researchers. This is of particular concern since due to the high cost and relatively long length of stay in nursing homes, even those residents who begin as "private pay" clients eventually use up their own resources and become Medicaid clients.

Research Review

Given this series of events which has made nursing homes the most heavily funded option for seniors needing care, what evidence exists to argue either for or against this as a policy choice? A substantial body of research has been developed over several years which addresses various aspects of the alternatives to institutional care debate. In spite of differences in time, place, methodology, and professional auspices, these studies have yielded remarkably consistent results. In general, this research can be categorized as addressing one of four major questions:

- What is the range of types of care needed by the aged? How many really need professional care?
- What are the professional services offered by nursing homes which its residents actually use? Are they being called upon to provide nursing care to sick people, or do they mostly provide room, board, and oversight to medically stable residents?
- What are the comparative results of populations treated for similar problems with extended hospital care or with short hospital stays combined with home health care?
- Are there really cost savings to be found in providing care in non-institutional settings?

Range of Care Needs

Of all of the studies which survey the aged population regarding the types of assistance they need, the most thorough and often cited study is one conducted by a team of researchers reported in the book Old People in Three Industrial Societies (Shanas, et al., 1968). This survey

compares the elderly in Great Britain, Denmark, and the U.S. on a variety of variables and on their health status, family situation, and care needs. Their findings indicate that in the U.S., less than 5% of the aged reside in institutions. Two to three percent were considered bedfast at home, and another 5-6% were housebound (but not bedfast). Eight percent were living independently but with limitations in functioning. Thus, roughly 15% of those over age 60 could probably use some level of assistance in the home. Yet 80% of all the elderly were living quite independently, with no limitations in functioning.

It is interesting to note that the range between countries was not as great as one might expect. While Great Britain had slightly fewer institutionalized elderly than the U.S., Denmark had slightly more. Denmark's percentage of bedfast or housebound was roughly comparable to the U.S., but Great Britain's was somewhat higher. Nevertheless, in all countries those living independently with no functional limitations comprised the largest share: 80-85%. Yet, proportionally 40 times as many elderly Britons than Americans receive home help services.

A similar study was conducted in Michigan in 1972 (Survey of Needs, 1972). This survey of the elderly conducted by Market Opinion Research also indicated a skilled care population of slightly less than 5%. Respondents were asked what activities around the home they required assistance with. Results were as follows:

Table 9.--Activities of Michigan Aged Requiring Assistance

Activity	Percent Needing Assistance
Housecleaning	10.5
Climbing Stairs	7.9
Walking Outdoors	7.0
Cutting Toenails	6.4
Meal Preparation	4.5
Hearing on Telephone	3.9
Walking Indoors	2.6
Bathing/Washing	2.4
Dressing (including shoes)	1.6
Eating	.6

(Source: Survey of Needs, 1972)

Thus, at least 10% of the subjects interviewed required assistance at home, and the figure is probably higher.

While this study also found a high proportion (85%) of the elderly living independently with no ongoing need for care, a report from the National Center for Health Statistics (1972) indicates that many more seniors may need occasional or intermittent assistance. Forty-two percent of those over age 65 are reported as having a chronic disease which will lead to some long-term limitation in activity.

Yet of all of these people requiring care, many are without any source of assistance. The Market Opinion Research study in Michigan found that 12% of all people

interviewed had neither friends nor relatives in their neighborhood. One-third had no child within 25 miles, and 17% had no living children.

In summary, then, it can be estimated that slightly less than 5% of the elderly are residing in institutions at any given time. Perhaps 80-85% live independently, with no long-term care needs. The remaining 10-15% could make use of varying degrees of assistance in the home. And many of the aged have no friends or relatives available to help.

Use of Nursing Home Services

Numerous studies have been conducted specifically of that 5% in nursing homes, usually centering around the concept of "appropriate placement." Both because of the high cost of nursing home care, and the frequent reports of provider fraud, public agencies are anxious to know more about who is receiving this care, and why.

One of the earliest of such studies was conducted as a part of the National Health Survey in 1968. This survey found that 13% of the nursing home patients studied were receiving neither nursing care nor unskilled personal assistance. Another 25% did receive personal assistance, but no nursing care. Thus 38% of the people studied resided in a skilled care setting, yet did not receive nursing services.

At the state level, research has yielded similar results. In 1971, a study was undertaken of 15 nursing

homes in five Michigan counties by the Comptroller General of the United States. This project used criteria established by Michigan Department of Public Health for level of care determinations, and used a joint state/ federal review team to study patients in skilled nursing care. Based on review of records, discussions with nursing staff, and patient observation, the team concluded that 79% of those studied did not require skilled care. (This does not mean that none of them needed to be in a nursing home, but perhaps at the lesser cost "intermediate care" level.)

A study sponsored by the Institute of Gerontology at the University of Michigan in 1973 focused on nursing home patients in the Detroit area (Barney, 1973). Findings of this study indicate that 40% of those studied were independent in the areas of activities of daily living, ambulation and personal hygiene.

Finally, research done in other states has substantiated the Michigan findings. In New York, a 1968 study concluded that 31.3% of those in basic (intermediate) care settings were being overserved: 28.8% would be more appropriately placed in personal care settings, and 2.5% had potential for independent living. And a study of six counties in western New York State in 1971 found that 27% of the nursing home residents reviewed were inappropriately placed at a higher level of care than needed. (A placement was considered appropriate unless two physicians reviewing cases independently <u>both</u> concluded it was inappropriate.)

Two studies done in Massachusetts (1971 and 1975) also point to overuse of nursing care settings. The 1971 study indicated that 40% of those surveyed would have been more appropriately placed in supervised housing or in the community. The 1975 study found misuse of the skilled care and intermediate care categories in proportions even greater than the Comptroller General's 1971 study in Michigan.

All of this is not to suggest, however, that there is no place for nursing homes in a continuum of services. Large portions of those currently in nursing homes do need the skilled care provided, as might many more people who are currently not receiving care. Both the Michigan Market Opinion Research study and the study by Shanas, et al., discovered significant numbers of people bedfast at home. And the Davis and Gibbon study also indicated that many individuals might be in need of more skilled care.

Importantly, these research findings are based strictly on medical review, and none have been able to take into account the factor of extent of family/community support available in determining whether home care is possible. That is, a person with some social support will be able to remain in the community even with a level of disability that would have forced a more isolated individual into nursing care. This issue of social support is also critical in interpreting research results indicating nursing home overuse. It cannot be concluded that these "overserved"

individuals should be placed back into the community, for many have lost their homes, and all contact with family and former friends after a few months in a nursing home. Thus, while waiting lists and other indicators such as some of the research just cited would suggest that some people need nursing care which is not available to them, it is not a simple matter to match need and setting once a pattern of misuse has begun.

Home Care vs. Hospital Treatment

Several research efforts have centered around the use of home health services. These studies compare a sample of people given reduced hospital care and home health services, with a control group receiving the usual hospital treatment.

St. Luke's Hospital Medical Center conducted one such study in New York City in 1971. Twenty-five stroke patients were given home health care while a control group was given hospital care. Comparison after nine months revealed striking differences. From admission to discharge, the average hospital stay averaged 11 days longer when no home care was given. Recovery was greatly improved for the home care group, as shown by the following table:

Table 10: Status of Stroke Patients 9 Months after Admission

Care Setting	Status after 9 Months		
	At Home	Nursing Home	Deceased
In-Home Care	22	1	2
Hospital/Control Group	8	8	9

In addition, differences in average health care costs over the nine months were significant. While the control group's mean cost was $8,204, the home care group was $3,368.

These findings are supported by a study done by Blue Cross (1973) in Michigan and Philadelphia, and by a study in Connecticut (Porter, 1975). These studies found a reduction in hospital stay of from 9-12 days (Governor's Task Force Report, 1976).

Benjamin Rose Institute, in Cleveland, Ohio was the sponsor of another home health study. This study also matched a home care sample (age 65+) with a sample receiving no home care upon discharge. The average number of days of institutional care needed was then compared after one year. The Benjamin Rose researchers found that while those not receiving home aides averaged 53 days of institutional care, those with home aides averaged only eight. In addition, for those people who had family available to assist in personal care, the presence of the home aide enhanced and strengthened the participation of the family.

Cost Issues

The final issue approached directly and indirectly by this body of research is the question of cost. Proponents of alternative care often argue that theirs is the low cost approach, either per capita or in total. As evidence, they cite figures on the high cost of (often unnecessary)

nursing home care compared to home health or chore assistance, as well as figures on the lessened need for intensive care developed by Benjamin Rose and St. Lukes.

Most of the cost studies which have been done to date have serious methodological deficiencies. The difficulties in acquiring standard definitions of service across settings, consistent means of establishing costs, and controlling a sample for the length of time necessary are nearly insurmountable. Indeed, so difficult is the problem, and so great a manual to assist managers in establishing their program costs.

Testimony prepared by analysts from the Urban Institute for presentation at hearings before Congress presents a more balanced view. William Pollak argues that regardless of the per case savings which might be associated with community care, total appropriations for health care will continue to rise due to population trends and the documented extent of unmet need for all types of care. He also suggests that no conclusive statement can yet be made on the question of per case costs, since no truly comprehensive comparative study has been undertaken. While nursing home rates include the costs of food, shelter, and staff, they do not include other costs such as physician's visits, medications, etc. Likewise, home or community care should include consideration of costs of food, shelter, and other supportive services, in addition to the hourly rate charged by the home health agency or chore provider. Opportunity

costs for family members and volunteers might also be quantified.

Pollak hypothesizes that in the long run, the major variable for cost of care will be the level of care needed, rather than the setting. That is, while those with relatively low intensity care needs may be most cost-efficiently served at home, at some point along a scale, the balance would turn. This would make more highly skilled care less costly when provided in a centralized setting. Pollak's view has been confirmed by a study of home health services (Widmer, Brill, Schlosser, 1978), and home chore services (Emling, 1976), where cost of care was shown to be related to the functional level of the client. None the less, no truly controlled, comparative cost study has yet been done to verify the savings claimed by proponents of alternative care.

Yet others would argue that cost should not be the issue at all. While the Michigan Office of Services to the Aging's task force report to the Governor itself argues that on a per client basis money could be saved through community care, the report also takes the position that community living programs should not need to justify themselves as lower cost alternatives to nursing homes:

> Costs are given close attention, of course, but it should not be forgotten that the single most important consideration of the report is quality of care. . . Independent living simply is the natural state of affairs. (Task Force Report, p. 48)

While no conclusive findings on cost comparative issues exist, charges and counter charges continue. Yet the quality of life issue remains largely unaddressed by public policy: Is the lowest cost option by definition the most socially desirable? What other factors, if any, are legitimate considerations in policy development? And at what point does an "independent party" have a right or responsibility to decide where another adult, with full rights of citizenship, shall live?

CHAPTER IV

THEORETICAL FOUNDATIONS FOR ANALYSIS OF STATE POLICY FOR THE AGING

> The relationship of politics and the state in economic and social theory is a vast, uncharted region in the arena of going theories. (Kolke, p. 287-8)

The issues raised by a study of state policy for the aging illuminate many critical questions regarding the nature of the state and the services sector in the economy of advanced capitalism. Thus, in its largest context, the care of the aging is a subject which can be usefully analyzed through theories of political economy, especially as they overlap with works on the family, medical economics, and professions. Indeed, the purpose of this dissertation is to explore the extent to which existing theory provides a useful and enlightening framework for understanding the case study under investigation. Two avenues of related theoretical questioning will be pursued: How shall the nature and functioning of the state sector of the economy be understood? What is the relationship of the state to the expanding services sector in general, and the field of health care in particular?

The Nature and Functions of the State

The nature and functions of the state have been approached by writers spanning a number of years, and from points of view as diverse as Adam Smith and Karl Marx. While some theorists address the ideal (what could or should be), others are more operational, analyzing the role of the state under a specific set of circumstances, at a given point in time, or as involved in a particular issue or decision. Most authors, of course, attempt to do some of each, making for a rich, if fragmented body of literature. Before beginning a detailed review of that theory, therefore, some general observations on the nature of this developing field seem in order.

For the most part, traditional theories of the nature of the state approach two extremes. One style of treatment, most common among those of the pluralist school, idealizes the state to be void of any economic content. The state is conceived of as strictly civic in character, and representative of the sum of the wishes of each of its individual citizens counted equally. In a somewhat more sophisticated version, the state might be seen as an impartial arbiter, representing some independent notion of the "public good" viewed from a remote and objective perch.

Approaching the other extreme are those authors who view the state as a mere byproduct of the class struggle, as but one of many tools in the arsenal of capital. This focus on economic (class) dynamics places the state as an

appendage of the ruling class created to promote the stability of the existing economic order: "In other words, any particular state is the child of the class or classes in society which benefit from the particular set of property relations which it is the state's obligation to enforce" (Sweezy, p. 242). Interestingly, this tendency to subordinate the role of the state to the larger interests of property can be traced to the classical economist Adam Smith, whose view was that the state was "necessary insofar as the maintenance of social order and property relations was concerned" (Kolko, p. 288).

In neither of these extremes is the state likely to be given the serious treatment warranted by its rapid expansion in recent history. Since government spending as a percent of the Gross National Product has increased from 7.4% in 1903 to 28.8% in 1961 (Baran and Sweezy, 1966, p. 146), it should be no surprise that the role of state spending should be of particular and increasing importance to those whose interest is in understanding the changes which occur in the various stages of capitalist economics. The impact of expenditures of that magnitude cannot be discounted, and the policy decisions as to where and how that money is spent become critical to the overall formulation of the political economy. In recent years, substantial thoughtful work has been done within the Marxist tradition on the functions of the state in its responsibility for guaranteeing the survival of the society, the stability of

the existing order, and the ongoing life of the economy with minimal disruption.

In the traditional Marxist view, the state is the mechanism by which the propertied class enforces its authority and maintains its position. For this reason, Engels (1902) writes that the primary purpose of the state is to protect and maintain existing property relations. In Capital (1967) Marx explores one example of state sector activity (the regulation of the length of the working day) in some depth. Yet for both Marx and Engels, the primary question to be studied was class relations. The state, as but one tool of the propertied class, was of secondary importance in their analysis.

Paul Sweezy (1970) provides probably the most succinct outline of those principles which can be drawn from the works of Marx and Engels. He summarizes three principles of the economic role of the state under a capitalist economy:

> In the first place, the state comes into action in the economic sphere in order to solve problems which are posed by the development of capitalism. In the second place, where the interests of the capitalist class are concerned, there is a strong predisposition to use the state power freely. And, finally, the state may be used to make concessions to the working class provided that the consequences of not doing so are sufficiently dangerous to the stability and functioning of the system as a whole. (p. 249)

Since the works of Marx and Engels, more contemporary writers have further developed the original Marxist

conception as they have observed the role of the state developing and expanding over time.

In what has become a landmark work on the nature of the state in advanced capitalism, James O'Connor (1973) sets the context for his analysis by outlining the character and composition of three sectors in capitalist economies. The monopoly sector is capital intensive, and consists of primarily unionized employees working for large, highly regularized corporations. The imperatives of growth within the monopoly sector are the driving force in the growth of the state. "As we have argued, the development of the monopoly sector indirectly determines the state budget by generating needs that the state must satisfy" (O'Connor, p. 64).

The competitive sector consists of primarily labor-intensive business, with little unionization. The commonality of interests between the state and the monopoly sector operates to the detriment of the competitive sector, where businesses must attempt to move into the monopoly sector or face continued struggle for survival.

The state sector has aspects of both the monopoly and competitive sectors. When the state contracts for provision of goods and services, it does so primarily with the monopoly sector. Yet its own workforce for directly delivered services compares with the competitive sector.

For O'Connor, the state sector of the economy can be understood as having two simultaneous, overlapping, but

contradictory functions: maintaining conditions favorable to the private accumulation of capital, and maintaining the legitimacy of the social order, especially among the non-propertied classes. All expenditures by the state can be interpreted as promoting at least one, and often both, of these aims.

O'Connor classified state expenditures which further accumulation as "social capital" expenditures. These include many civic programs which in effect reduce or underwrite the cost of doing business. Because social capital adds indirectly to the expansion of surplus value, social capital is considered by O'Connor to be indirectly productive. Social capital expenses of the state can be further thought of as two types: social investment and social consumption.

Social investment consists of those projects which the state provides which are either too costly, or too risky, for individual capital to undertake. In large part, these are infrastructure expenses: highways, railroads, communication systems, regional development, industrial parks. Such expenses would clearly be too high-cost for any individual industry to bear, yet capital as a whole benefits from the socialization of these costs to the taxpayers.

Social consumption, on the other hand, is expenditures by the state which increase the rate of profit by reducing the reproduction costs of labor. By absorbing the cost of services to working people (schools, mass transit,

child and medical care, benefits for the laid-off and unemployed), the state enables a lower level of wages to be paid. That is, if individual workers needed to purchase such services directly (rather than through their taxes or the unpaid labor of a housewife) higher wage or benefit demands would lower the profitability of the industry.

Whether through social investment or social consumption, state spending on projects which increase the rate of profit to capitalists is a critical element of the overall economy. Contrary to traditional economists, O'Connor argues that "the growth of the state sector is indispensable to the expansion of private industry" (p. 9), and increasingly demanded by capital. Since this state sector spending is financed primarily through taxes on the working class, state purchase of goods and services to further social investment or social consumption represents a net gain to the private sector. In fact, O'Connor argues that it is precisely the rise in the need for state support of private accumulation greater than can be supported through tax revenues (without rising a legitimation crisis) which constitutes the fiscal crisis of the state.

O'Connor takes the position that state spending, since it furthers capital accumulation and socializes many costs of private capital, is critical to the parallel expansion of capital; that the two go hand in hand. In this view O'Connor is supported by Baran and Sweezy, who outline the argument in a slightly different way.

Advanced capitalism is characterized by Paul Baran and Paul Sweezy (1966) as an economy burdened by surplus. Productive capacity exceeds potential markets, and so lies unused. Even massive advertising and the creation of needs cannot bring demand in line with potential supply. In this situation, government spending (which purchases goods and services, recirculates income into the hands of new employees) represents a new market. It adds to demand and allows production in the private sector to occur closer to spending in an age of surplus and unused productive resources actually allows the economy to expand:

> If what government takes would otherwise not have been produced at all, it cannot be said to have been squeezed out of anybody. Government spending and taxing, which used to be primarily a mechanism for transferring income, have become in large measure a mechanism for creating income by bringing idle capital and labor into production. (Baran & Sweezy, p. 150)

Thus, for Baran and Sweezy, ". . . the big question, therefore, is not whether there will be more and more government spending, but on what" (p. 151). Their work, Monopoly Capital, investigates the many dimensions of the monopoly sector, including its extensive need for state intervention and support (especially militarily and in international affairs). Their conclusion, like O'Connor's, is that wherever possible, state purchases and contracts will be done with the monopoly sector (or at least in a manner supportive of it) due to the existence of unused capacity which the monopoly sector is alert for avenues to employ. This relationship between the state and the monopoly sector (their mutual

growth, interdependence, and sensitivity to each other's requirements) works to the demise of the competitive sector.

In another major work giving substantial attention to the development of the nature and functions of the state in capitalist economies, Nicos Poulantzas (1978) addresses the role of the state in the class struggle. Because the class struggle he outlines in both economic and social, Poulantzas' work bridges O'Connor's notions of the state's accumulation and legitimation functions. For Poulantzas, "the state has the particular function of constituting the factor of cohesion between the levels of a social formation" (Poulantzas, p. 44). This "global function of cohesion" (p. 51) puts the state squarely into an activist role in controlling the class struggle on both the political and the economic front.

In the political class struggle, the purpose of the state is to represent the interest of the ruling class beyond the vision of individual competing capitals. By having the state "representing unity," private interests can pursue their primary economic goals with the state representing and serving their longer-term interests as a class.

> The state simultaneously acts to organize the dominant classes as a political force and to politically disorganize the dominated class. Both of these functions necessitate autonomy from the dominated class. . . (Gough, p. 65)

In the economic class struggle, Poulantzas outlines the role of the state as being that of "isolation," or the division of potentially dangerous coalitions. That is,

in the economic sphere, the common interests of the masses must be masked. The ideology of individualism and its correlates (land of opportunity, etc.) promoted by the state conceals the common condition of the non-propertied classes and keeps economic self-interest depoliticized. By maintaining the ideology of justice and equal opportunity self interest is focused at the individual, rather than the class level.

While much of Poulantzas' work certainly addresses how the state functions to maintain prosperity for the ruling class (accumulation), I see him as providing considerable insight to the less-developed "legitimation" side of O'Connor's equation. For the intricacies of the class struggle have less to do with the profit/loss balance sheet than the social politics of how the state maintains belief in the structure's legitimacy among those dispossessed by the economic system.

As an aside, Poulantzas also sheds some interesting light on the observation made earlier about the two polar trends in analysis of the state. Tracing the Marxist notion of the "bare individual" to its roots, Poulantzas explores whether there is any foundation for the idea of a strong and independent removed and neutral state. Poulantzas indicates that from his perspective the notion of civil society or a separate state has no grounding in a Marxist analysis p. 124-125). In a related vein, Poulantzas addresses the difficult question of the role of an ongoing state bureaucracy which

was called to attention by Max Weber (Gerth and Mills, 1946). He returns to distinction made by Marx and Engels between state power and state apparatus, concluding:

> So while the bureaucracy has no class power of its own, nor does it directly exercise the power of the classes to which it belongs; furthermore, it fails to do this precisely because it belongs to those classes. (Poulantzas, p. 336)

Ernest Mandel's book Late Capitalism (1975) is a final work in political economy which has central implications for this subject. This exhaustive work integrates many aspects of works discussed here, applying analysis of developments in capitalism since World War II. While he uses his own terms and definitions for the functions of the state, the argument is not unlike others reviewed thus far:

> The main functions of the State can be classified as follows:
>
> (i) Provision of those general conditions of production which cannot be assured by the private activities of the members of the dominant class.
>
> (ii) Repression of any threat to the prevailing mode of production from the dominated classes or particular sections of the dominant classes, by means of army, police, judiciary and prison system.
>
> (iii) Integration of the dominated classes, to ensure that the ruling ideology of the society remains that of the ruling class, and that consequently the exploited classes accept their own exploitation without the immediate exercise of repression against them. . . (Mandel, p. 475)

Like Baran and Sweezy, Mandel sees one aspect of the state and capital being the provision of "additional opportunities on an unprecedented scale for 'profitable' investments of this capital. . ." (p. 484-485). Similar to Poulantzas' notion of the state representing the unity of

the ruling class, Mandel sees the state representing the "ideal total capitalist" beyond the interests within capital (p. 479). Mandel and Poulantzas do seem to disagree, however, on whether the role of the state with the dominated classes is to isolate individuals by masking commonalities and encouraging narrow self-interest (Poulantzas); or to emphasize the myths of integration which keep the dispossessed still believing in the legitimacy of the social order (Mandel). And, not unlike Max Weber, Mandel recognizes that in late capitalism an increasing economic role is played by "professional" government administrators, foundations, and think-tanks which work directly with capital (p. 490-491).

Finally, in what may be Mandel's most unique contribution to the study of political economy, he addresses in detail the expansion of the services sector, addressing when, and under what circumstances, capital will be interested in entering the services sector. In an historical review, Mandel traces the development of the services sector through the industrialization of agriculture, noting the tendency both technically and economically for centralization (p. 383). Mandel concludes that over time the services sector evolves from that of private labor sold to an individual purchaser of service (like the woodcutter considered by Marx in Theories of Surplus Value) to a capitalist form. At the same time, Mandel points to the socialization of services, to demands on the public (state)

sector for financing and distribution. The goals of capital in the services sector are to reduce the turnover time of capital and speed recirculation without reducing the actual surplus value produced (Mandel, p. 399). To this end, capital will penetrate where it can replace a use-value (p. 392), or private labor (p. 388). The ultimate goal, however, is to convert the service into a commodity for production (e.g., a washer and dryer for every home). Short of that goal, however, with the state as the main contractor or consumer, the capitalist organization of services represents an alternative to the problem of surplus and unused capacity so aptly outlined by Baran and Sweezy.

> As long as "capital" was relatively scarce, it normally concentrated on the direct production of surplus-value in the traditional domains of commodity production. But if capital is gradually accumulated in increasingly abundant quantities, and a substantial part of social capital no longer achieves valorization at all, the new mass of capital will penetrate more and more into areas which are non-productive in the sense that they do not create surplus-value, where it will displace private labor and small enterprise just as inexorably as it did in industrial production 200 or 100 years before. (Mandel, p. 387-388)

In summary, what contributions have been made by political economists to understand the nature of state spending? First, as the overall dynamic of capitalism seen in a variety of industries, the pressure over time is to move from labor intensive, to capital intensive, to commodity forms. When those areas which are directly productive have been exhausted, the same dynamic applies to services.

More than other industries, services can be understood to be socialized in the sense that the state provides them

either directly or through contract. The state is particularly active in the "services sector" in order to increase the profitability of accumulation (i.e., socializing many costs of production which appear as public services), and to maintain the legitimacy of the existing order (the funding of services which maintain the dispossessed).

Yet, the state's relationship to services is not injudicious. Specifically, the state will invest in services first in a way which supports the monopoly sector, establishing mechanisms which enable meeting legitimation needs to also serve important accumulation functions. Based on this conclusion, one would expect the state to deliver long-term care to the aged in a manner which establishes, cultivates, and maintains opportunities for profitability to the private sector. To be effective, a desired policy change would need, in some way, to account for this basic dynamic.

Implications in Health Care Theory

As outlined in the introductory chapter to the dissertation, there is a small body of literature--especially the work of Vicente Navarro (1975, 1977)--which attempts to link theories of political economy with analysis of the health care industry. In the first, Navarro's analysis parallels O'Connor's three sectors of the economy and attempts to identify the monopoly sector of the health care industry, finance capital and insurance. In the second, Navarro examines the role of state intervention, and how the

health care industry mirrors the larger capitalist economy in the aspects of class hierarchy, ideology, and alienation.

Also applying political economy to the field of health care, Kelman (1971) in an historical analysis, traces the development of modern medicine from a cottage industry to its modern capitalist form. In Kelman's view, the high technology, capital-intensive fields of health care (hospitals, research facilities) parallel O'Connor's characterization of the monopoly sector, while the labor-intensive branches of medical care (i.e., physicians) would be comparable to the competitive sector.

Mark Renaud (1975) draws a parallel between the overall emphasis on production/consumption, and the forms of health care delivery of capitalist economies. While he views most major health problems as social problems arising from our economic organization, he argues that state intervention is limited to subsidizing further consumption of health remedies, rather than addressing those causes. The role of the state in providing health care serves a legitimation function for the general public in Renaud's analysis, while simultaneously fostering accumulation through subsidizing the commodity/consumption approach to health care.

While each of the authors approaches the question from a different framework, each does agree that within the health care field there is a monopoly segment which operates as O'Connor, Baran, and Sweezy, and Mandel would expect in relation to the state. For Navarro, the monopoly sector is

the investment and finance institutions, which operate with exchange of personnel and social class unity with the state. For Kelman, the dialectic is that from medicine as a cottage industry, to the industrial capital model, to the finance capital stage detailed by Navarro. Marc Renaud, while not addressing the monopolistic forms of medicine, elaborates on the limits of state intervention into the health field, consistent with the primacy of the accumulation function of O'Connor.

For the purposes of this dissertation, it is important to remember that the field of long-term care is but a small segment of health care. Indeed, most medical sociology works within the framework of the health care industry as a whole, predominated by acute care, sophisticated research facilities, highly trained and male-dominated professions, and a vast commitment of resources. The entire range of long-term care occurs within the lowest rung of the larger medical field: Long-term care of the chronically ill, especially the aged, represents the least "interesting" and "rewarding" of the health care work (Freidson, 1970), involving more maintenance work than actual treatment. Thus, while nursing represents the high-status "professional" level of care in the context of long-term care, overall in health care professions, nurses have low status. For this reason, this dissertation has not explored fully the potential ramifications of the professions literature, since its applicability would be tenuous at best.

The range of long-term care to be considered within this study begins with simple wage labor: home chore services. The middle case, Adult Foster Care, represents the cottage industry form, as Kelman would describe it. These homes, mostly of the "mom and pop" type do none the less have business finance in capital to the extent that one's home is also one's business. Within the range of care choices available for the state to support through its policy, nursing homes most closely represent the monopoly form. If this conceptualization can be supported through the evidence presented in Chapter 5, then theories of political economy would seem to go a long way in providing insight into public policy. Specifically, if the state sector must provide services in a way compatable with the accumulation of profit by the monopoly sector, and if nursing homes are indeed that sector, the odds against the movement for alternatives to nursing home care would be formidable.

CHAPTER V

THE CASE OF LONG-TERM CARE

In this chapter, a market analysis of three industries within the field of long-term care will be undertaken, for the purpose of examining the extent to which the theoretical base just outlined can provide a useful explanation for the policy contradiction described in Chapter 1. Through the examination of the actual operating characteristics of two community-based care options (home chore services and adult foster care), and one institutional setting (nursing homes), important aspects of similarity and difference can be highlighted. Indeed, this comparison covers the full range of market conditions from a wage-based service, a cottage industry, and a highly developed capital form. These three markets will be compared on the basis of their: extent of capital investment, labor characteristics, reimbursement source and mechanism, licensing and regulation. The ways in which each is developing and changing will be discussed, especially as it relates to the theoretical foundations just established.

Before beginning, however, a brief description of each type of care will add to the clarity of the case analysis. Home chore services are available to the aged and disabled

who can maintain independent living with assistance in their homes. A family member, friend, neighbor, or arranged provider will be paid to a maximum of $280/month for providing housekeeping, laundry, meal preparation, shopping, yardwork, or personal care assistance. The work to be done, hours, and rate of pay are all negotiated on a case-specific basis between the client, provider, and caseworker.

Adult foster care is a program through which a provider makes a licensed home in the community available for the placement of the aged or disabled who cannot live alone, yet do not need the skilled care provided in a nursing home. Adult foster care homes provide "room, board, and supervision," with an additional rate for those also needing personal care such as assistance with dressing, bathing, grooming. The supervision component is the major service available in adult foster care which is not available in chore services. Thus, the senile or mentally disabled who must be watched, reminded, have medications monitored, but who do not need ongoing medical care would be appropriate for adult foster care.

Nursing homes, as described in the historical background, acquired a technical definition with the advent of Medicare and Medicaid in 1965. These facilities may be of two levels of care: "skilled" and "intermediate" or "basic." Standards for type and amount of staff and services in such facilities vary, but in general they are designed to provide a longer-term care than is appropriate

in a hospital, for one who needs more ongoing medical monitoring and treatment than community-based services provide.

Extent of Capital Investment

The capital requirements of any market are important for several reasons, including that it limits the number of providers who can enter the field. In addition, as will be shown, the existence of some capital investment is the beginning of the ability to increase profitability through reinvesting, leasing, depreciation, and other such methods.

Indeed, it requires no savings or investment to enter the home chore service market. Providers simply sell their labor for a wage. Because there is no capital investment in plant or facility, there is also no potential for accumulation. As an indicator of the lack of resources required to provide chore services, it has been estimated that between 10 and 30% of the in-home providers are also Public Assistance Clients (Emling, 1981).

Adult foster care, on the other hand, involves capital, since one must have a home which meets certain licensing standards in order to be a foster care provider. To the extent that the rate a provider is reimbursed covers the cost of room and board for the resident, the provider's investment in his home is paid for by the state while it accumulates in value as a business (Fallek, 1975). Indeed, a small number of AFC homes in the urban areas are now owned on a "chain" basis or run by a "non-profit"

corporation similar to nursing homes, exercizing the ability to use one home as collateral for another (Emling, 1980, Kasprzak, 1980).

Even this, however, is miniscule compared to the capital transactions of the nursing home industry, where the existence of the facility and its mortgage (coupled with the rate of reimbursement) become the basis for significant increases in the rate or return.

> Their basic strategy is to manipulate the ownership and mortgaging of nursing homes receiving guaranteed government income in order to extract the most revenue and pay the least amount back in the form of income taxes. . . (Y)ou might build a nursing home and rent it, at a very high figure, to a "non-profit" corporation you or your friends have created. The government will pay more to that corporation, because of the high rental, than it would have paid you directly based on the cost of building the home. The extra payment comes back to you, of course, in the form of the extra high rent. (Mendelson, p. 47)

Also, Mendelson (p. 48-9) points out the manner in which one's initial investment in one facility can easily be transferred to a number of others, thus increasing one's capital holdings:

> Manipulating mortgages is another aspect of profit-making in industry and the nursing home. Despite the many protestations to the contrary, there is no safer risk than the nursing home. With guaranteed government revenue, with a growing elderly population, with a shortage of homes, there is, as the Wall Street expert said, "no way" not to make money in this business . . . .
>
> I have been struck by how many profitable homes have mortgages that grow instead of decrease. Normally you would expect the home, as it makes money, to pay off its mortgage. Instead, the owners of these homes keep adding to the burden of debt that the homes are carrying.

Of course, the reason that such manipulations are possible and profitable for nursing homes is the method of reimbursement, which covers "full cost" without distinguishing unnecessary costs. This will be discussed further under "reimbursement," but it does explain the difference between AFC homes and nursing homes in this use of their capital investment. In his book, Moss (1976) reviews the extensive number of state and Federal government reports which document these, and other types of capital manipulations which lead to the high profitability of the nursing home industry.

Labor

As had been pointed out in both the political economy literature and the studies of the health care industry, the extent to which a sector of the market is labor-intensive is important in understanding its profitability. The progression in the services sector from labor-intensive to capital-intensive to commodity production outlined by Mandel would indicate the labor-intensive form to be currently least profitable, but with potential for future capital development.

Among the three types of care considered here, home chore services are the most highly labor-intensive, consisting of individuals selling their labor power to other individuals who (through subsidy by the state) purchase that labor to acquire the needed services. In fact, within the monthly maximum of $280 a provider could receive minimum wage for a maximum of only 20 hours/week. If the client needs

more in-home care than that, the provider must either agree to "volunteer" time, or consider the hourly wage to be less than minimum wage. State policy and appropriations have consciously sought to artificially limit the payment rate to keep down program costs.

Because of an elaborate rationale to avoid state liability for benefits to chore providers, the client is considered the employer. Chore service providers receive no benefits, often less than minimum wage, and until recently compliance with Social Security laws was spotty at best. Thus, since most providers are family and friends (Emling, 1976), a considerable amount of use value is still occurring in chore services where providers exhibit competitive sector characteristics (91% female, 30% under age 30 or over age 60).

Adult foster care can be seen as the "cottage industry," consisting of both use value (the labor of the family is contributed but not formally reimbursed in the rate calculation) and hired wage labor. In order to meet licensing standards regarding resident:staff ratios, the larger AFC homes must begin to employ staff. In the facilities of 6 to 12 residents, this often consists of a generalized person who helps with the kitchen, cleaning, and resident care and supervision. In the larger homes (of 13 or more), direct care staff may be differentiated from kitchen, maintenance, cleaning and grounds work (Emling, 1980; Kasprzak, 1980. Indeed, in a few of the large homes,

operated by non-profit chains all staff are hired; no one with ownership in the facility lives on the premises (Emling, 1980). At this extreme of the AFC market, the adopting of nursing home characteristics is apparent.

In a number of cost studies yielding similar results, the cost of staffing overall in AFC facilities was approximately 25% of all operating costs. The range, however, is from 7% for family homes to approximately 40% for the large group and congregate homes (Fallek, 1976, Hale, 1977, Kasprzak, 1980).

Finally, in nursing homes staffing requirements are somewhat greater than for adult foster care, including a nurse/supervisor. Typically, the staff is unskilled and low paid, leading to problems of turnover and resident abuse documented by Mendelson, Butler, and Moss. While nursing homes may involve more paid staff than the other types of care discussed here, they do not qualify as labor-intensive. The key to their business is not the selling of labor power; it is the capital investment in physical plant and in the purchase of inexpensive labor power to operate the facility at a profit.

Reimbursement

Several factors surrounding reimbursement are critical to understanding the differences between the community-based and the institutional markets discussed here. First, of course, is the method of reimbursement: the manner in which the rate is calculated, the incentives it provides,

and its adequacy. However, in dealing with state-funded services, the source of the funding is also telling for the different assumptions and biases which are built into the formula. Often, more than one source of Federal matching funds would be available for the same or similar service; the state's choice of which one to use makes important differences for the program and the provider.

Home chore services is paid in the form of a monthly lump-sum check made out jointly to the client and the provider, avoiding the direct responsibility of the state as the employer. Within the legislatively established maximum of $280/month, whatever services that are needed must be negotiated (the average payment is approximately $190/month, per latest DSS payroll warrant data). The maximum has increased only $10, from $270, since the program's inception in 1973, in spite of inflation which has affected every other program's costs. Importantly, chore providers are paid through a one-time authorization by a Social Services worker. Payment automatically continues monthly until a worker directs the payment to stop or change. Such a system implies that these providers are considered a "low risk" for mispayment or audit exception. Nursing homes, by comparison, must submit a monthly bill in order to activate payment..

Over the past year, extensive discussions have occurred over the issue of changing the Federal funding source of this program in order to save an estimated

$16 million in state funds. This funding change involves the "personal care" portions of the chore service, which are now being claimed under a provision of medical care within Medicaid. Among the many considerations involved in making this change were fears that the recognition of this as a "medical" service would result in cost increases which could reach beyond the $16 million.

There is likely to be pressure from the "medical community," for example, to require trained providers, thus limiting the supply and increasing the cost. And certainly the method of rate determination will become a greater issue, with reimbursement tied more realistically to the hours of care provided and the going wage rate in the community, and perhaps a requirement for positive billing. Indeed, this "fund source shift" may mark the first step of what appears in this analysis as wage labor, into another stage of development (perhaps akin to home health agency services such as the Visiting Nurses Association).

Adult foster care is reimbursed through the Federal Supplemental Security Income (SSI) program, with federally administered state supplements to the national standard. In Michigan, the amount of state supplementation is decided in the legislative process tied to the basic per diem (room, board and supervision) plus a higher rate for personal care.

Over the last several years, pressure for increases in the per diem (currently $11.64 and $14.55 per day) has

resulted in executive branch "Rate Setting Advisory Committee" activity. Studies of actual operating expenses in AFC homes were undertaken in 1975 (Fallek), 1977 (Hale), and 1980 (Kasprzak), each of which indicated that providers were living within the existing rate; each of which became a justification to request a rate increase. While it has long been contended that the rate does not include all costs experienced by providers, or programming components which would be desirable, it seems clear from the records of these meetings that the actual components of the rate have never been defined. (This makes the question of what is not being reimbursed academic, at best!) However, because the AFC rate is tied to the Federal SSI program, there are automatic cost of living adjustments made to the base each year which for the most part are passed along to providers.

Indeed, the original AFC rate to which updates have occurred, included the costs of facility and food, but not staffing. The current rate structure includes a slightly higher payment for clients with more personal care needs; it does not distinguish by size of home in spite of the licensing requirements for resident:staff ratios. It is a matter of state policy to encourage the smaller homes; thus no willingness to pay a higher rate to the larger ones. Perhaps ironically, the evidence seems to be that the most cost-efficient size of home is from 12-15 residents. The small homes, while they have less costs, are unable to reap advantage from economies of scale.

The medical claim for personal care services which was discussed and implemented for home chore services, has also been legislatively targeted for AFC beginning in July, 1981. Again, this will save state supplementation, substituting Federal funds. The Adult Foster Care provider association (Statewide Home Care Association) has expressed concern that this will lead to more requirements being placed on providers with no increase in rate, especially additional bookkeeping or training (Hale, 1980).

Thus, while the rate determination for AFC does not include the specific cost considerations and full reimbursement which is implied in nursing homes, it is based on a flat rate per resident which bears some relationship to documented cost. In general, the question of AFC rates is a "middle order" political issue: There is some legislative activity by providers, but not of the amount or strength of the medical community.

Reimbursement mechanisms for nursing homes vary considerably, and are established by different methods in each state within the federal requirement of "reasonable costs". In general, however, they consist of variations of three major themes. First is the flat rate (like that used for adult foster care in Michigan). A flat rate takes into account what is presumed to be an average per-patient cost for reimbursement. It is generally considered to be the method which most encourages providers to achieve profit at the expense of resident care (Fallek, 1975; Mendelson, p. 39;

Moss, p. 140). The second, more costly method, is "cost-plus." In these systems, a variety of ways of calculating "reasonable cost" exists, and a profit add-on is included. Finally, the latest trend among the largest (and highest spending) states is a prospective reimbursement system (Lewin & Associates, 1980). Prospective systems use evidence of costs in a past year to determine a fair rate with updates through the current year. It is assumed that this gives the provider incentive to practice cost containment beyond the base year, but not to excessively cut corners. The critical issue, therefore, to both providers and the state is how to build the base year figure.

Importantly, there are several goals which reimbursement methods must juggle. In practice, these goals may be mutually exclusive. For example, a rate should not encourage providers to cut costs on essential items such as food in order to increase profits, which a flat rate system does; neither should they have no incentive to practice cost containment on those items such as office furnishings, which a cost-plus formula does. There should not be incentives to pad the beds with clients needing little care (in fact, those the research outlined in Chapter 3 discovered) to reduce costs; yet, a flat rate virtually denies care to the high-need patient. However, a scale based on need leads to artificial inflation of costs. In his work, Mark Fallek (1975) outlines the limitations of what controls can be accomplished through

reimbursement formula alone. Regardless of state and reimbursement methodology, it appears that nursing homes have managed to become high-investment material due to the federal requirement for "reasonable cost-related" reimbursement, and therefore the covering of whatever costs of construction, financing, leasing are incurred on paper.

Michigan has recently changed from a "cost-plus" system in reimbursing its nursing homes to a prospective one which also figures an add-on for profit. In the Conference Committee of the House and Senate Appropriations Committees for the Department of Social Services budget for Fiscal Year 1980-81, several issues related to nursing home rates were considered. First, because of the state's financial difficulties, it was decided to reduce the per patient per day profit add-on from $1.50 to $.50. (Providers have succeeded in getting this raised again for the 1981-82 fiscal year.) Second, staff were added to conduct a "re-basing," since the legislature was concerned that the prospective base year data might have included some inappropriate costs. Importantly, representatives of the hospital and nursing home associations remained throughout the committee deliberations which extended until 1 a.m. on a Saturday morning, actively pursuing Legislators in the lobby, and being invited to participate in the deliberations to provide their views at key points.

While the specific rates to be paid for nursing homes are a function of the political process in each state, it should be noted that the Federal requirements for Title XIX

(Medicaid) contain many protections to providers with which states must comply. These include language requiring "full-cost" reimbursement, as well as specifications of a 60-day notice period if any reduction in rates is to occur, etc. Thus, it is clear that funding source as well as rate setting mechanism add to the protection of the "medical" providers. The strength of participation of providers in the policy process is strong in Washington, for that is the key to what each state is able to do. The necessity of concessions to the medical professions is clear in the fascinating legislative history of Medicaid. Further, in the years since its establishment, interests and investments in its provisions have grown.

Licensing Standards

It is important to note the extent of licensing requirements which apply to the various providers and settings, for these regulations serve many important functions. First, because they dictate the standards of the facility, they form the basis for claims of cost due to professionalism, expenses of maintaining standards, etc. Second, they serve to limit the market, since providers who cannot afford to bring a facility into compliance must change businesses. Finally, it must be noted that it is virtually impossible to regulate qualitative aspects of care; yet it is possible to regulate basic safety. The number of fires each winter in facilities which cost the elderly and mentally disabled their lives points out the

importance of sprinkling systems, for example, which are highly contested by providers due to their high cost. Particularly for the aspect of limiting competition by controlling entry, licensing standards are important to understanding the provider markets under discussion. As Kolko and Weinstein point out, here the state consults with the largest and most influential providers, and regulates protective standards which serve to limit competition.

As mentioned previously, there are currently no requirements as to training or certification required of chore service providers. It has generally been assumed that anyone qualified to keep his/her own house was qualified to help someone else. This premise, however, is questioned by certified health aides and other paraprofessionals, who are likely to escalate this debate with the increased visibility of medical funding for personal care. Nevertheless, since the service is provided in the client's home, there are no licensing standards for the facility, and ease of entry by providers into the field is quite open.

Adult foster care homes in Michigan are governed by licensing standards which are considered to be models around the country. Indeed, many states make extensive payments to providers in an SSI category called "room and board." These are unlicensed facilities (downtown hotels, etc.) housing the equivalent of Michigan's AFC population.

In Michigan, licensing requirements vary by size of home, requiring less of those family homes which care for fewer than six residents, and relatively more for small group (7-12 residents), large group (13-20 residents), and congregate (21 or more) facilities. This assists to meet the program goal of encouraging the smallest, family homes.

Importantly, since the advent of licensing in Michigan (which came some 20 years after some homes had been in the "room and board" business) an interesting phenomenon has been noted. Among those facilities whose capacity was at the margin of a new standard, many chose to drop to the next lower category to avoid higher licensing requirements. Particularly for those with capacities of 21 to 25 or so, the cost of the sprinkling system required for congregate status was too high. Thus, facilities reduced capacity to 20 to qualify under the large-group requirement of smoke alarms instead.

Indeed, those homes which could not come into compliance at all simply dropped from the adult foster care program to become "room and board" homes. While under this arrangement providers forfeit the direct SSI/state supplementation payment, and the placement services of state social workers to fill their vacancies, the resident in "independent living" would qualify for SSI individually, and could be charged a fee by the provider as a "private pay" arrangement. Thus, one important and unfortunate side effect of licensing is that for residents in those homes

squeezed out of the market there is no longer any mechanism to afford the client protection from an unscrupulous provider.

As pointed out in the history section, the efforts at effective licensure within nursing homes have been long and somewhat less than productive. While again the reputation of Michigan is higher than that of many other states, there are considerable difficulties within the state on standards of nursing home care (Technical Workgroup on Health Care Costs, 1973; Senator Otterbacher, 1977).

Of major concern to most client advocates is the category of "substantial compliance" which was originally established to meet the immediate need for beds with the implementation of Medicaid and Medicare. These categories still comprise facilities with substantial and dangerous non-compliance problems. Yet all that is required is that they move <u>toward</u> compliance (at an unspecified rate), not that they ever achieve it. Each of the industry "experts" (Mendelson, Moss, Butler) express pessimism about the potential for increasing regulations to result in improved standards.

The Technical Workgroup on Health Care Costs points out (p. 296-7) the pressures that proprietary homes place on licensing agencies, and discusses the practice of advance scheduling inspections. The even more cynical (Mendelson, for example) point to case after case where licensing and regulation were inadequate or inadequately

enforced, and even occasional evidence of complicity of inspectors and welfare workers in blatant violations.

Importantly, those few facilities that do end up under pressure from licensing standards may take the route of the adult foster care providers and resort to seeking license under the next lowest level of care; in this case, Adult Foster Care! It is worth noting that prior to the advent of Medicaid funding, many nursing homes were old, converted large family homes. Since 1965, the size and bed capacity of nursing homes has been increasing under new construction (with costs built into the reimbursement rates), and many of those old family homes are now AFC residences.

Provider Political Organization

As an undercurrent to each of the previous sections, the question of the amount and effectiveness of the providers' political organization is deserving of direct discussion. This is an especially difficult subject to research, for those who are best organized are also so unobtrusive. Because it is rare to find a source willing to address this subject in a straightforward manner, I have chosen not to make it a major point of my analysis; yet it cannot be overlooked.

As might be guessed, home chore services has no organized provider association. The provider group consists of individuals scattered throughout the state. One-third are either parents or children caring for one-another with state supplementation to their income. In fact,

15% of the chore service providers are themselves senior citizens (Emling, 1976, 1978). It is worth noting, however, that the provider association for AFC homes has recently broadened its title, and when both chore and AFC providers become "personal care" providers under the Medicaid reimbursement plan discussed, they may move to expand their constituency.

Adult Foster Care providers have two associations in the state of Michigan, State-Wide Home Care Association which represents primarily group homes out-state; and East Side Home Care Association, representing large home operators from Wayne County. These provider associations provide services to members, such as a monthly informational newsletter, insurance programs (which are quite problematic to acquire commercially), and representation in Lansing.

The State-Wide Association seems to be especially active within the Department of Social Services, especially with the policy staff and the Rate Setting Section; they are represented on the rate-setting advisory committee, for example. Given Mendelson's description of the citizen taskforce meeting she attended on her first day at work (stacked with nursing home representatives arguing that if only the rates were higher the quality of care would improve) (p. 3-4), this does not seem to be unusual. The Wayne County provider association seems to give particular attention to relations with legislative representatives from districts with heavy concentrations of AFC homes,

judged on the basis of inquiries by letter and telephone received from Legislators in these districts.

Within the state of Michigan, responsibility for nursing homes is diffused between the Department of Public Health (licensing, certifying need for care), and the Department of Social Services (Medicaid funding to handle the bill). Even rate-setting questions are handled on a contractual basis with Department of Public Health. Thus, the activities of the provider associations are not as readily obvious. Nonetheless, former state senator John Otterbacher, who chaired a committee on nursing home reform, has indicated publically that the nursing home industry is "among the top three most effective lobbies in Michigan" (Michigan League for Human Services Conference, Spring, 1978). Given the strength of those lobbiests which come immediately to mind in an industrial state like Michigan, it does come as some surprise that the quiet work of this group is so strong. At the national level, the American Nursing Home Association (a federation of state associations) represents primarily the proprietary homes, The National Council of Health Care Services represents the new and growing nursing home chains (Butler, p. 285-6). These political organizations represent provider interests on the range of subjects discussed here, with particular focus on regulation and reimbursement.

The Comparative Case of Mental Health

Compared to the evidence presented in Chapter 1 on the actual progress--or lack of it--in achieving deinstitutionalization of the aged, a look at the system of mental health treatment presents a different picture. Over the last eight to ten years, a substantial number of institutional releases has resulted in the actual closing of state treatment facilities. Since 1960 the resident population in state facilities for the mentally ill has dropped from 19,059 to 4,858 and since 1967 the resident population in the state facilities for the developmentally disabled has dropped from 12,694 to 5,025. At the same time the number of individuals with a primary diagnosis of mental illness or mental retardation in community residential settings has risen to about 18,000 (LaFollette, 1980). What are the factors which enable the state to pursue its policy of community care more effectively for mental health clients than for the aged? This question is particularly intriguing in that the task of deinstitutionalization would appear to be much more difficult with the mentally disabled. Frequent publicity in the papers over community resistence to the establishment of neighborhood group homes is but one example of the ways in which local citizens and government jurisdictions have attempted to roadblock deinstitutionalization through restrictive codes, zoning, and other ordinances, extended public comment and hearings periods, etc. Yet,

institutional staff are being laid off at an increasing pace, and clients are indeed being moved to community settings.

Perhaps the major factor in the ability to control deinstitutionalization of mental health clients is simply that the facilities being endangered are state-run. Unlike the attempt to reverse nursing home placements, the attempt to close state facilities poses no threat to the private sector. Controlling the beginning (or extreme) of the continuum of care, mental health officials are able to direct the process and pacing of deinstitutionalization in a way that is impossible with private sector investment in facilities (such as nursing homes).

Second, licensing requirements have in the case of mental health served as an impetus for deinstitutionalization. When confronted with the choice of operating facilities out of compliance, making substantial capital investments to bring them up to standard, or selectively closing some facilities and improving others, the cost factor was controlling. The policy of deinstitutionalization averted potential state costs for improvement of facilities which were threatened with denial of licensure.

Third, and parallel to the first, the impetus of the private providers in mental health is in the community. The private sector, having no role in insitution, but with the potential for a new market with deinstitutionalization, has cooperated and indeed pushed for

deinstitutionalization. In the mental health system, community treatment facilities are well reimbursed (far in excess of adult foster care providers), and appear similar to nursing homes in their profit potential and market characteristics.

Thus rather than attempting to shift from the most profitable private setting to less developed markets (as with the aged), the movement being attempted within mental health is the reverse. It is interesting that in spite of the great amount of community resistance to accepting mental health patients in the community, this shift is actually occurring. While the aged are relatively more welcome in community settings, the shift is not occurring, or at least is much less dramatic. The reverse economic dynamics would seem to hold a major key in the explanation of why this is so.

Conclusion: Profitability and the State

Based on the theory discussed in Chapter 4, a number of observations would be expected in the actual markets for long-term care for the aged. First, one would expect to see a range of degrees of market development, especially since the field of long-term care is a part of a developing services sector. That is, there would be some markets consisting of wage labor, some of cottage industry, and a variety of stages of corporate-style organization. Ultimately, some aspects of the market would be identified as having potential for commodity production and sale on a

mass consumer market. Second, the state, in the process of undertaking those tasks which are necessary for legitimation (care of the aged citizens), will do so in a fashion which is supportive of the capitalist form of the market. And, finally, within the industry pressure will exist for movement in the direction of that monopolistic, capital-intensive form of service organization.

In this case study, it can be seen that nursing homes follow most closely the monopoly characteristics of O'Connor: Through the licensing process, the market has been limited, with those excluded cast off to the competitive realm of AFC. With control of access to the market, cost-plus or other lucrative reimbursement method, close links to the state which ensures that its needs are met, the nursing home fits the analogy of Navarro for the high capital, "professional" equivalent to the monopoly sector.

Adult foster care can best be seen as a cottage industry, representing the "middle case" in this analysis. While it does have some licensing requirements as gatekeepers, it is reimbursed on a flat rate which does allow some profit, and has a state-level provider organization. Yet, it still depends substantially on contributed labor of the family, is a business operated in most cases out of a residence. Adult home help, at the farthest extreme, is a wage labor and use value market at present, showing signs

of pressure to begin movement along the dimensions discussed by Mandel as a part of the expanding services sector.

Thus, it can be concluded that the literature of political economy does indeed provide a useful framework for understanding the existing market relations within the long-term care industry. In the concluding chapter, the implications of this theory for the movement for alternatives to institutional care will be re-assessed, and some prognosis made as to the likely directions of the movement in the future given the understanding of the state and the services sector acquired here.

CHAPTER VI

CONCLUSION

Summary

This dissertation begins by presenting a problem to be explored and explained: a contradiction between the skeleton of the state (which strongly supports nursing home care for the aged) and its misleading ideologies (which expound the commitment of the state to in-home care). In spite of years of maintaining the pretext that a program of in-home care has replaced nursing homes as the primary care setting in Michigan as well as around the country, the actual experience of seniors in terms of availability of and access to community care is little different than it was ten years ago. This dissertation begins by examining the dimensions of need for in-home and community alternatives to nursing homes, through use of sociological, historical, and survey research evidence.

A picture of who is in need of care, how they have come to need it, and how they might have been cared for in the past are a part of this documentation.

Theories of political economy point to characteristics of the capitalist state in relation to a service: (1) The state will work in concert with, and in a manner supportive of, the

monopoly portion of the industry; and (2) Pressure will build within the other sectors of the industry to move along the various stages from labor to capital-intensive. Where the state enters into the provision of a service in order to maintain social stability, it should be understood that this will not be done at the expense of the capitalist class as a whole, and that it will be done to their benefit as far as is possible. Within the health care field, the "monopoly sector" can be variously understood as either that one having the highest amount of capital and investment, or that having the highest professional status.

In Chapter 5, the case is established for conceiving of nursing homes as the monopoly portion of the long-term care industry, setting adult foster care as the cottage industry formation, and home chore services as the wage labor portion of the market. In terms of extent of capital, type of labor, reimbursement methodology, licensing and regulation, and extent of political activity, there is a range in the stage of development of the long-term care. This analysis, drawing upon a political economy understanding of the nature and functions of the state, helps explain the contradiction and stalemate in the development of policy for long-term care. These theories suggest that if one sector of the market is much more highly capital-developed, state policy would need (due to the fundamental nature of the state and the capitalist economy) to operate in a manner supportive of that industry. Thus can be seen the circular

and reinforcing nature of the state in relation to the monopoly sector of long-term care. Certainly, the existence of nursing homes before Medicaid created a dependence on them under the new law. Yet, the availability of Federal funds administered in a sympathetic manner led to an expansion of that sector, and a rapid rise in their profitability. The dynamic of availability breeding use has left little room for the creation or expansion of alternative forms of care within the fiscal limits of the state. The theoretical works on the state in advanced capitalism do indeed form a useful framework for interpreting the events under consideration in this dissertation. It is indeed expected, and far from surprising, that a turn-around of priorities in long-term care would be unlikely to happen, as long as any reduction in the security of the nursing home market is involved.

Finally, I would like to reflect on the future of the movement for in-home and community care, in light of the insight gained through this analysis. While the analysis I have provided helps explain the predominance of nursing homes in the long-term care market in an advanced capitalist economy, must this situation continue? In what ways, within the needs of both the state and capital, might this issue evolve? Basic to this question is the need to identify the various futures which are likely and to outline what they might mean for care for the aged. Many terms are currently used in reference to the future of capitalism, e.g., state capitalism,

state socialism, socialism, and communism. Yet no systematic definitions exist which would give insight as to how the provision of long-term care might fit into these possible futures.

On the Present--Monopoly Capitalism

As descriptive terms, monopoly capitalism, state capitalism, and state socialism have two major characteristics. First, they attempt to show the source of power: monopoly or state. Second, they describe the flow of economic surplus: capitalism, socialism. These terms, however, have been used by different authors in different ways.

For example, some refer to the current U.S. political economy as monopoly capitalism, believing this accurately reflects both the source of power and the flow of surplus. Other authors (including James O'Connor) prefer to use the term "state capitalism" to describe our current arrangement, on the principle that until now we have been too blind to the role of the state in supporting private profit. Still other authors (Baran and Sweezy, p. 66-67) do not recognize state capitalism as an economic form.

Perhaps the best place to begin to clarify this confusion is with a discussion of the present economic system, which will be referred to as monopoly capitalism. Chart A (attached) outlines the position of monopoly capitalism, as well as state capitalism and socialism on a variety of dimensions. Some of these characteristics of monopoly capitalism deserve mention here.

The source of revenue in monopoly capitalism is primarily an income tax which is not distributed progressively across the population:

> Changes in tax rates and the tax structure, the main forms of modern fiscal policy, have increasingly favored corporate profits and growth. And with the tax shelters and loopholes available to monopoly capitalists, the whole system is based, in effect, on the exploitation of the working and small-business classes, particularly monopoly sector workers whose taxable incomes are relatively high.
>
> (O'Connor, p. 208)

In monopoly capitalism, market principles still hold sway regarding the basic organization of labor, if not of capital. That is, individuals enter the market and sell their labor power for an hourly rate or salary: "... the labourer purchases the right to work for his own livlihood only by paying for it in surplus-labour..." (Marx, in Dowd, p. 32-38). This system is mediated to some extent by the existence of unions and gatekeepers such as Civil Service but basically the individual may accept or decline the amount offered in exchange for one's hours of labor (declining, of course, having important personal consequences). As Marx said, the worker really does pay his own salary by producing enough in his required hours to both pay for his own wages, cover other operating costs, and still generate a surplus.

Services in monopoly capitalism are also distributed on a modified market model. Service availability is dependent on its profitability to the contracted provider. In short, through government subsidy, reimbursement, or contract, a

profit must be guaranteed before a provider will enter a service market. Provider availability may thus vary from region to region. This applies to a wide variety of services, from road construction to Medicare providers. While other businesses enter a market unsure of their ability to generate a profit, in the services sector, a profit must be virtually guaranteed.

Services also follow the market model in that the controlling factor in individual access is ability to pay. For those private-pay seekers of transportation, for example, taxis and buses will do in absence of a car. For a Public Assistance client, however, with no ability to pay, virtually no transportation services exist. Thus the establishment of providers is dependent on the decision that a profit can be made; access is limited to those who can help generate that profit. For some services, this involves massive subsidization of both provider and client by state (taxpayer) dollars.

State Capitalism as an Alternative

State capitalism, as discussed here, differs from monopoly capitalism in the element of primary control - of whether the basic needs of profit or some notion of collective good will come first. State capitalism does not connote state ownership necessarily, although one would predict that many industries (particularly energy and utilities) would be nationalized under such a system. The major difference

between monopoly capitalism and state capitalism is that planning and priority-setting would occur through public channels (somehow without distortion from capital interests). Allowable rates of profit would be determined and regulated, and future directions encouraged through incentives. Thus, the state would control decisions such as whether to develop public transportation at the expense of passenger cars, or whether solar or nuclear energy represented the preferred alternative for the future. Then, either through incentives/disincentives, or through state-owned industry, these established national choices could be implemented. One framework for a state capitalist system is outlined by Shonfield (1965), highlighting its major characteristics.

Under state capitalism, of course, the state would have a need for revenue at least as great as under monopoly capitalism--although it might refuse to pick up the tab for as many of the social costs of industry. All the same, revenue is necessary to better serve the collective needs of the country. These revenues would be generated from a variety of sources: state industries would include those with productive capital (unlike the Post Office), and would be self-supporting. They would also have the capacity to generate some surplus if it was deemed necessary to raise revenue for other state priorities (O'Connor, 1975). Owners of capital which was still private would be taxed according to assets. Perhaps a device such as the negative income tax would both have self-sufficient members contributing to the

financial well-being of the nation while insuring a standard of living for all. Incidentally, social costs such as welfare would be reduced in this system by the increased control of government over industry, and by government's increasing role as employer.

Ideally under state capitalism the distribution of services could be better planned and controlled. Rather than leaving it to "market forces" whether a particular service is available in a specific locale, the planning process would allow such gaps in service to be identified and planned for. Since the rate of profit for any industry would be controlled, a smaller margin of profit would be sufficient to lure providers. Also, the state might more actively pursue direct service provision, e.g., actually hiring medical service professionals or construction crews. Thus the major differences would be in the rate of profit allowed, the planning to identify needs systematically, and the increased role of direct service provision.

In summary, then, state capitalism differs from monopoly capitalism in the question of who is to hold the major power: corporations or a national representative entity. That profit would exist in some private hands in either system is inherent in the term "capitalism"; yet state capitalism would be much more highly regulated, and even proprietary business would survive by serving the national interest. Centralized planning and administration would replace piecemeal and decentralized influence-pedaling as the method for setting priorities for national development.

Socialism as a Political/Economic Alternative

As an intermediate form between state capitalism and socialism, one could conceive of a system of "state socialism" which can be seen in those systems characterized by complete nationalization, as opposed to collectivization. Like the difference between monopoly and state capitalism, the difference between state socialism and socialism is at best one of degrees.

Socialism, then also has need for revenue, but in a slightly different sense than does capitalism. It does not need to generate wealth for individuals, but needs to generate enough surplus to allow development in new sectors or expand the standard of living of the population (Sweezy 1970). With individual workers guaranteed a standard of living, the surplus from any enterprise (agricultural or industrial) accrues to the collective, for collective decisions about its use. Therefore, there would be no need for taxes in the sense that they are thought of in the United States, for rather than giving only to take away, the process of pay-determination would be controlled to begin with.

The organization of the labor process in a socialist system would be with collective work groups with rotating responsibility. The workers of a plant would truly control it, for they would be the management as well. Since all labor power would be needed for collective good, unemployment

would be virtually unknown (unlike monopoly capitalism, where much essential work goes undone because it is perceived as not profitable). Thus, work (who does what) would be a political issue (rather than one of economic scarcity), and labor could be assigned or rotated as needs were raised to political consciousness. At any rate, all labor power would be used, and a basic living standard guaranteed in return for one's contribution to the whole.

Also reflecting the ability of a socialist economy to consider local needs as well as national goals, the distribution of services would follow the national/local mix. That is, most services would be directly provided or delegated to a working unit, but their availability would not be dependent on profitability or ability to pay. If day care thus became an established national priority, the surplus generated (mentioned before) would go to the development of a national day care system. However, if a particular region had other pressing needs, it could organize and seek support for that problem as well.

In summary, the movement to further define the traditional terms of "capitalist" and "socialist" by pointing out variations is essentially a method of showing the source of political power as well as the economic structure. What might these differences (i.e., between monopoly capitalism, state capitalism, and socialism) mean when applied to the future of long-term care for the aged?

On Care for the Aging

While for the most part our current economy can be described as monopoly capitalism, it is interesting to note that in the area of services we have moved decidedly closer to the description of state capitalism. This is because in monopoly capitalism the state is called upon to socialize many of the costs of production, and this has led to a rapid rise in one sector of the economy (the state sector) which resembles what the entire economy would look like under state capitalism, (see James O'Connor, chapter 1). Thus, in the services sector the state does control the flow of resources, and theoretically could attach incentives and disincentives for the kinds of programs it favors or deplores. It can control planning, and could indeed insure the level, quality, and availability of various types of services throughout the country. The main reason this has not occurred to the extent that it could conceptually is in the nature of the political process which is still under monopoly capitalism. That is, we do not yet have the policy process implied by state capitalism which would make planners free of monied interests. Indeed, monied interests have prevented effective planning and control in the services market while maintaining a high rate of guaranteed profit.

The area of services to the aging is complex, covering needs for support for living arrangements (in own home, in relative's home, group living, and supervised or skilled nursing facilities), income support, and other social needs

(transportation, health care, home-delivered meals, adult day care and activities centers). Each of these areas is currently funded (if such services exist at all) under different titles of different federal matching requirements, provider stipulations, quality controls, and authorizing agency. Obviously either state capitalism or socialism would radically alter this situation, involving as they do rational planning and a view of the total picture of needs, services and delivery mechanisms.

Under state capitalism,services to the aging could be funded (similar to the current situation) by federal/local match money for approved programs. The difference would be in the policy process occurring before such money was made available. Stronger federal mandates would be given for the purpose of the money, and programs which needed to operate in coordination would be planned and required to do so. Specifically, for example, a federal goal would not be stated "develop adequate care", but "develop in-home alternatives to nursing home care". And in the process, Medicaid (home health agencies) and chore services programs would be required to submit joint plans for a comprehensive home-care package.

Also in the policy process, national standards for licensing and allowable profits would be specified for any projects where federal funds were to be used, and documentation of compliance required. This is in contrast to the current situation in which programs funded under different titles have no requirement to coordinate, and states

set standards (such as they are) for quality and licensing. Of course, any amount of profit one can wring out is currently allowable, in spite of budgets that admittedly cannot serve all of the people in need.

Organization of labor in services to the elderly under state capitalism would include both regulated proprietary agencies and non-profit agencies, as well as individuals, at various levels of training. This would be done to try to correct the current imbalance of providers, which makes some services much more difficult to acquire in out-state regions. Nevertheless, it is unclear whether the state capitalist system could be wholly successful in eliminating the regional variation in service availability. If enough money can be made in a limited area, and profits are controlled, incentives to expand would have to be provided in other ways, or few providers would bother to set up new operations. Encouraging independent local agencies, rather than chains of institutionalized ones, might be one approach.

Under state capitalism, then, the aged might be confronted with a slightly more rational system in terms of planning and access to programs. Eligibility, once proven, might be established for a host of coordinated programs--housekeeping for the disabled, home health, and home-delivered meals, for example. A needs assessment and referral process might exist between income-maintenance programs. The relative level of funding for such programs (always low in comparison to children's welfare or family income programs) would still

be a political battle waged at the level of national planning. While any systematic priority setting process should help improve the relative position of seniors programs, it still could not be guaranteed under state capitalism that the needs and contributions of our elderly would be adequately considered.

A socialist system, by virtue of planning process which accounted for citizen input and local contributions to national goal-setting, might go a long way to alleviating the problems which a state capitalist system could not alleviate. If seniors themselves were allowed to voice their needs, and if local flexibility were allowed, as well as national standards (i.e., to account for differences in need between urban and rural aged, for example), a national needs assessment could be more effectively implemented.

Also, since all services would be in effect directly provided (since everyone is working for the same collective good), gaps in geographic availability could more effectively be met. State planners could mandate areas of need and channel state development funds into those areas, rather than relying on the 'bid for contract' system which would presumably exist under state capitalism. Finally, since revenues come from the surplus generated, both local and national problems could be addressed by collective funds generated at either level. Again, while the question of priority of services for the aged in comparison with other

social needs could not be anticipated, citizen involvement in planning would assure some semblance of balance.

Finally, probably the most significant difference for seniors between any type of capitalist system and any type of socialist system would be the relative value of their own contribution. So far, this study has only spoken of what seniors need, not what they have to give. This is because in capitalist countries, with the need to artificially control the labor supply, seniors are put "out to pasture" at relatively productive ages, and are allowed little further contribution to society. With little further purpose for living, mental and physical deterioration are quite rapid. Under socialism, there are a whole host of needs the elderly could be meeting in addition to their usual like-work. Rather than lose the value of their experience in society, they could be effective contributors to the planning and leadership for their collective/community and nation.

Probably nothing is so important in preventing dependence and the need for support/services than the sense of importance found through being a contributing member of the society in which one lives.

The Implications for Long-Term Care

Within the foreseeable future, conditions of monopoly or state capitalism seem likely to apply, with the services sector in flux between them. Given the characteristics of monopoly or state capitalism outlined above, what are the

realistic futures open to the movement for alternatives to nursing home care?

To encourage the process of evolution from nursing home to community care, other, equally profitable investment opportunities would need to be offered to the nursing home. (It is therefore not surprising that new construction for nursing homes seems to have anticipated the possibilities, designing facilities which would easily convert to motel usage.) However, even within the field of care for the aging, some compromises might be reached. Nursing homes, for example, could be part of a new market, in the provision of short-stay respite care for the disabled whose families or other caretakers need relief. The facilities could be used to meet the growing demand for adult day care and out-patient community health care, the kitchens serving as sites for senior nutrition programs or in the packaging and delivery of home meals. In the state of New York, the approach of offering nursing homes a new future is being tried in a "Nursing Home without Walls" program. Such creative alternative uses of existing resources may well be the ground where a form of state capitalism would settle. While retaining the necessary sensitivity to the needs of capital, the control of policy goal incentives by the state could enable the currently "misleading ideology" of home and community care to be a reality for seniors.

FOOTNOTES

[1]Many have written about the various strategies used to divide the poor, masking the similarity of their interests and confounding attempts to organize (Piven and Cloward, 1971, 1979). One deep division among the poor has been that between the aged and these with young families. Derthick (1979) traces how the Social Security Administration has mobilized sentiment in favor of the aged ("deserving poor") to expand Social Security - an economically inefficient, but population-specific "solution" to the poverty problem. Expansion of programs for the deserving (aged, disabled, often without a means test) has blunted the impetus behind welfare reform by chipping away at those aspects of poverty on which there is some amount of political consensus.

[2]In a fascinating analysis of Social Security, Martha Derthick (1979) examines how administrative and political decisions have been made affecting Social Security. Within the administration, reliance on the "insurance" concept to legitimate expansion has been strong. Use of General Fund financing has been opposed because it undermines the politically useful "trust fund" notion, and because it would put Social Security on terms of equal competition with many other programs for dividing the budget pie. Indeed, while the Reagan administration proposals do begin to attack the base of social definitions in an attempt to cut back Social Security, both former administrations and Congress have treated a benefit once offered to be a matter of insurance contract for continuation of coverage.

[3]A growing body of literature addresses the complex relationship of the family and public institutions in caring for the dependent. Zaretsky (1971, 1973), Rothman (1971), Lasch (1977) and Brown (1979) trace a number of themes in the history of families and the state under capitalism: institutions as benevolent or instruments of social control, professional notions of proper care and upbringing, the needs of capital.

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