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INSIDE AND OUTSIDE THE FOR-PROFIT NURSING HOME:
SOME EXTERNAL DETERMINANTS OF INSIDE POWER RELATIONS

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ABSTRACT

This paper offers a conceptual model for understanding how and in what ways externally determined factors affect power arrangements within a for-profit nursing home setting. Specifically, this paper links the activities of nursing homes as profit seekers to federal legislation and the activities of strategically structured interests which seek to socialize their costs. Additionally, it shows how social distinctions and other factors which have their origins external to the nursing home setting have consequences for what takes place inside. The model posits that it is those people who are members of society's more privileged groups (professional white males) who will get access to positions of power in part because members must go outside the organization into the greater society to obtain the certification which will allow them to occupy powerful positions. Consequently, those who have power inside the organization (professional white males) are very similar to those who have power in the greater society. Moreover, observational data indicate that those statuses which members of the nursing home enter with are associated with patterns of interaction and levels of control and authority. Finally, there is an attempt to spell out the implications of such findings and an attempt to show how government and community (non)involvement (could) affect relationships internal to the nursing home.

As Jansson (1979:362) suggests, "a crucial policy choice that must be made by public agencies and officials is whether . . . to provide publicly funded services themselves or to utilize nonprofit or profit-oriented organizations in the private sector." More and more often, policy makers are depending on the profit

oriented, private sector to provide social services; however, the costs of providing such social services continue to be met by the state (O'Connor, 1973).

Recently, theorists have attempted to outline the consequences of capitalists' attempts to socialize their production costs and expenses while keeping profits in their own hands (e.g., O'Connor, 1973; Braverman, 1974). For example, Braverman (1974:271) argues that to the extent that capitalists are successful in passing their costs on to the state while reaping profits "the capitalist mode of production takes over the totality of individual, family, social needs, and in subordinating them to the market, also reshapes them to serve the needs of capital." He argues that with the transformation of the society into a giant market which benefits state-subsidized capitalists,

the population no longer relies upon social organization in the forms of family, friends, neighbors, community, elders, children, but with few exceptions must go to market and only to market, not only for food, clothing, and shelter, but also for recreation, amusement, security, for the care of the young, the old, the sick, the handicapped (Braverman, 1974:276).

Braverman goes on to argue that "since no care [for the young, the old, the sick, and the handicapped] is forthcoming from the community, and since the family cannot bear all such encumbrances. . . the care of all these layers become institutionalized" (p. 280).

Presumably, because these changes in the care of humans are more often to meet the needs of capital than to benefit those who make use of the services, the care for humans becomes more profit-oriented and more removed from humanistic concerns. The care for the young, the old, the sick, and the handicapped becomes more and more the responsibility of total (care) institutions which seek profit. But to see precisely what consequences this drive for profit has, one must look inside the walls of those total institutions which are profit-oriented.

While he is not specifically concerned with profit-oriented total institutions, Goffman (1961) does look inside the walls of

total institutions. In his works on total institutions--"places of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life"--Goffman (1961:xiii) discusses the roles that members of these institutions play. He points out that while many of these roles appear to be "natural," they are for the most part based on the ability of the various actors to make their definitions (of what should be done) binding for others. Many of these differences in ability to make binding definitions can be explained in terms of differences in interaction patterns and content of interactions (among inmates, between inmates and staff, and among staff members). However, to understand why these patterns of interaction exist and persist, it is often necessary to look beyond the walls of the total institution in that the total institution's internal structure reflects the dominant values and priorities of the external society (Clegg and Dunkerley, 1977; McNeil, 1978; Salaman, 1978). Moreover, the distribution of resources, privilege, and control inside the organization are related to the distribution of power in the broader society (Alford, 1975; Wolff, 1977; Martin, 1980).

However, as Martin (1980) notes, studies of internal organizational structure typically look at groups internal to the organization and ignore linkages between them and others outside the boundaries of the institution. As she notes, such views of organizations are deficient.

In order to understand how a given total institution affects the behaviors and relationships of its members, not only must one look at the interpersonal interactions within that total institution, but s/he must also examine those factors (mostly) external to it which facilitate and reinforce what takes place inside. Such an attempt is made here. This paper examines the nursing home as a privately owned, profit-oriented, but largely state-subsidized total institution. An attempt is made to determine how (and to what extent) externally produced/determined factors (e.g., organization of payments, demographic characteristics of staff members, professional certifications, governmental involvement, etc.) impact relationships within the nursing home. Of special interest are those institutional characteristics which are consequences of the nursing home's

"free-market" profit orientation while receiving state subsidies.

NURSING HOMES AND THE STATE

In the past, shorter life spans made nursing homes and other long-term care institutions virtually unnecessary. Brody (1977) notes that the proportion of elderly people was not very large before this century, and that it has been only in the past 50 years that a rapid increase in this proportion has occurred. She states that "sheer demography, then, was one of the major pressures producing growth of institutional facilities" (Brody, 1977:11).

But demography is not the total answer. As O'Connor (1963:41) points out, "monopoly capital and labor also have favored socializing social consumption expenditures such as medical costs and workers' retirement income." Thus, they have supported programs which have been important to the growth of state-subsidized nursing homes: the Social Security Act in 1935, the Hill-Burton Act in 1946, and Medicare and Medicaid in the mid-1960's. Alford (1975) argues that there have also been strategically structured interests in the health professions which have historically fought for the passage of such legislation in the form that it has eventually passed.

According to Reichert (1975), an important intent of the Social Security Act was to take older people out of the job market during the depression era. He argues that disruptions of the extended family, housing shortages, and new mobility among wage earners all increased the demand for nursing homes. However, because the law prohibited payments to residents of public institutions, people took their relief money and moved into private homes. Typically, these nursing homes were unregulated and often of poor quality. Local and county governments entered the picture by offering financial support to those facilities which agreed to meet certain minimum requirements.

In 1946, the Hill-Burton Act was passed, guaranteeing that those willing to build and operate nursing homes could be assured of financial assistance from the federal government. Needless to say, this gave (potential) owners of nursing homes more incentive to go into business.

In 1965, the Medicare and Medicaid amendments were added to the Social Security Act. Among other things, these amendments provided for coverage of medical payments for the elderly and the indigent in extended care institutions and skilled nursing homes. With the advent of Medicare and Medicaid payments for patients in nursing homes, nursing home expenditures rose more than 500 percent from 1966 to 1975 (Gornick, 1976). For 1977, outlays for nursing home-related costs reached \$12.6 billion.

According to the National Center for Health Statistics (1978) there were approximately 18,300 nursing homes in the U.S. as of 1977. Of these, over 70% were for-profit operations. These for-profit homes owned approximately 70% of the 1,383,600 beds in service. Though over 70% of nursing homes are profit-oriented, a major source of funding for them has been and continues to be federal-state cost sharing programs such as Medicaid and Medicare which pay for many of the health care-related expenses of nursing home patients.

In 1977 for example, the average total monthly charge for patients who used Medicare as their primary source of payment for services in a profit-oriented nursing home was more than 75% greater than total charges for patients who used their own money to pay for services in nonprofit and government nursing homes (\$754 per month compared to \$427 per month).

Clearly then, the state's involvement has facilitated the growth and profitability of the nursing home industry. But the (non)intervention of the state and the greater society also affects other aspects of the nursing home. The remainder of this paper will examine some of those factors which originate outside the boundaries of the nursing home but have consequences for what occurs within the walls of the nursing home. Much of what follows is based on data collected from a case study of a profit-oriented, state-subsidized nursing home.

METHOD

Data related to the interpersonal relationships within profit-oriented nursing homes were collected as part of a case study of Huron View Lodge (HVL) nursing home. The data were collected from October of 1980 to April of 1981 using the

participant-as-observer technique, archival research, and interviews. During the initial stages of the study, the investigator assumed the role of a volunteer worker. Later (in January) he revealed his "researcher identity."

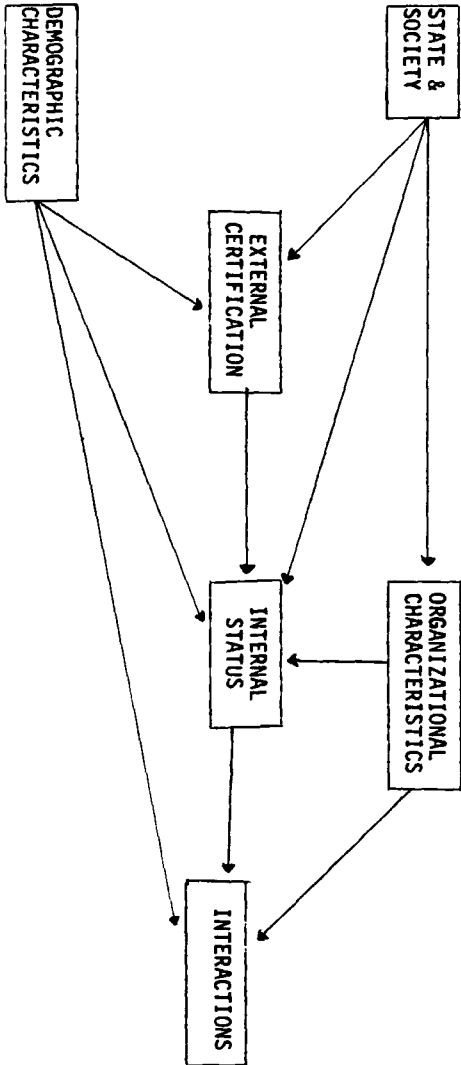
While the participant observation techniques employed in this study have some drawbacks, most notably generalizability, they offered some definite advantages: They allowed the investigator an opportunity to view behaviors of nursing home patients and staff in the social context of the nursing home itself. They provided him the chance to study patterns of interaction in more detail than might have been possible using other methods. This method also facilitated the use of controlled quasi-experiments in which the investigator initiated actions. And finally, participant observation, when combined with the archival data, enabled the investigator to more fully understand the influence of the "social structure" of the nursing home on the nursing home members.

FINDINGS

As mentioned, in order to understand the effects of the institutional setting on behaviors and relationships, one should consider factors both inside and outside the institution. Figure 1 presents a conceptual model of some of those factors which are important to understanding how and in what ways externally determined factors have effects within the institution. Specifically, this model posits that it is those people who are members of society's more privileged groups (professional white males) who will get access to positions of power within the institution. This is true because workers must go outside the organization into the greater society in order to obtain certification, a type of gatekeeping mechanism which allows only the "worthy" to occupy powerful positions. Consequently, those who have power inside the organization (professional white males) are very similar to those who have power in the greater society. For this reason, this model predicts that one's position inside the institution will be a function of his/her status in the society at-large. It is expected that power arrangements and patterns of interaction, therefore, will parallel those found beyond the walls of the institution.

The following four dimensions will be examined in this

FIGURE 1.
Conceptual Model of How External Factors Affect Interactions In Total Institutions



section of this paper: (1) the characteristics of the institution, (2) characteristics of members which exist prior to and external to the nursing home setting, (3) types and patterns of interaction which take place within the walls of the nursing home, and (4) the extent to which institutional labels and identities are promoted, facilitated, and reinforced by the state and the general society.

Kart and Manard (1976) concluded that ownership type, size of facility, demographic composition of membership, and professionalism of staff were determinants of the quality of care that nursing home patients would receive. While no inferences about the quality of care will be (explicitly) made here, such information will be presented.

First (and probably foremost), Huron View Lodge (HVL) nursing home is a profit-oriented, but heavily state-subsidized institution. It is a family-owned corporation with two co-owners. Not unlike many businesses, HVL is a member of the local Chamber of Commerce; moreover, it holds certificates of membership to the National Association of Nursing Homes, the Michigan Hospital Association, the Association of Health Care Homes, and the American Health Care Association.

Huron View Lodge, a 71-bed facility, is slightly larger than the average privately owned, profit-oriented nursing home facility which has approximately 63 beds (NCHS, 1978:Table 142). It is a skilled nursing facility which offers speech therapy, physical therapy, occupational therapy, X-ray facilities, and scheduled diversional activities to patients. (In February, 1981) HVL's rate of full-time or equivalent employees (FTE) providing direct health-related services per 100 beds, 59.2 was also higher than the average facility's 45.1. The composition of its staff by professional status, race, and sex is presented in Table 1.

In trying to determine patterns of interaction, dominance, and social control, one is well-advised to remember that members in total institutions "typically have statuses and relationships in the outside that must be taken into consideration," for as Goffman (1961:76, 122) points out, "there will always be . . . some use made of social distinctions already established in the environing society. . . ." With this in mind, it is reasonable to expect that a member's status external to HVL is a determinant of

Table 1.
Composition of Staff by Professional Status, by Race, and by Sex

<u>Professional Status (N=81)</u>	<u>Percent</u>
Professionals	21
Nonprofessionals	79
<u>Race (N=81)</u>	
Blacks	37
Whites	63
<u>Sex (N=81)</u>	
Males	32
Females	68

his/her status inside the nursing home. For this reason, it was hypothesized that the amount of control --ability to make rules which are binding for oneself and other institution members -- one has within the confines of the nursing home is related to factors such as his/her professional status, race and sex which originate external to the nursing home. This hypothesis is consistent with the conceptual model presented in Figure 1 and will act as a (partial) test of this model. Data relevant to testing this hypothesis are presented in Table 2 in terms of percentages of staff members with much control as a function of professional status, race, and sex.

The results from this analysis suggest that externally originating statuses are related to levels of control. For example, at HVL, no black males (0%) have much control, 5% of the black females have much control, 29% of the white males have much control, and 53% of the white females have much control. While it is likely that much of the difference in level of control can be attributed to the proportion of each subpopulation which has professional status (all χ^2 's are statistically significant at $p < .01$), it should be noted that the strength of association between levels of control and professional status varies from one subpopulation to the next. For example, for black females, there is a perfect association between professional status and level of control; i.e., the Goodman-Kruskal lambda and Cramer's phi

TABLE 2.
Percentage with Much Control by Professional Status, Race, and Sex

STATUS	RACE				TOTAL
	BLACK		WHITE		
	MALE	SEX FEMALE	MALE	SEX FEMALE	
NONPRO	0% (n=9)	0% (n=20)	8% (n=13)	36% (n=22)	14% (n=64)
PRO	-- (n=0)	100% (n=1)	100% (n=4)	83% (n=12)	88% (n=17)
TOTAL	0% (n=9)	5% (n=21)	29% (n=17)	53% (n=34)	30% (N=81)
No Measures of Association are possible		% Δ = 100% χ^2_{LR} = 8.0 df = 1 Lamda = 1.0 Phi = 1.0 p-val \leq .01	% Δ = 92% χ^2_{LR} = 13.5 df = 1 Lamda = .80 Phi = .86 p-val \leq .01	% Δ = 47% χ^2_{LR} = 7.4 df = 1 Lamda = .38 Phi = .45 p-val \leq .01	

measures of association are equal to 1.0. The lambda and phi for status predicting control for white males are .80 and .86 respectively. For status predicting control for white females, lambda = .38 and phi = .45. Because there are no black males at HVL who hold positions with professional status, there are no measures of association between status and control for this subpopulation.²

These findings are important to the extent that those with much control can and do define organizational goals and are able to use organizational resources for their personal and professional interests. In the case of HVL, the most powerful determinant of having much control is one's professional status.³

As Alford (1975) points, because of licensing practices of the government, such professionals are virtually guaranteed a monopoly on certain kinds of decisions and policies.

These professional monopolists . . . are able to provide a symbolic screen of legitimacy while maintaining power in their own hands through various organizational devices. A continuous flow of symbols will reassure the funding of allegedly controlling publics or constituencies about the functions being performed, while the individuals or groups which have a special interest in the income, prestige, or power generated by the agency are benefitting from its allocations of resources (Alford, 1975:194).

In other words, it is from the society external to the nursing home that professionals derive their levels of control on the inside. The same is true of other statuses, but only to a lesser degree. To show just how these externally originating differences are (become) relevant to patterns of interaction in the nursing home, further analysis is provided.

Such findings are also important to understanding the internal structure of HVL in that there is a profound hierarchical division of authority, decision-making, and labor. While such organizational structure is not peculiar to HVL, nor nursing homes in general, in this particular setting it has some rather interesting consequences for patient-staff and staff-staff interactions. Most notably, because of this division of authority and division of labor, and the existence of a "that's not my job"

attitude toward providing services to patients, many of the wants and some of the needs of the patients go unattended.

Unfortunately (at least from the patient's point of view), decision-making on even the seemingly most trivial matters takes hierarchical channels. As Perrow (1972:36) points out, "hierarchy promotes delays and sluggishness; everything must be kicked upstairs for a decision either because the boss insists or because the subordinate does not want to take the risk of making a poor decision." This is bad news for patients in that higher ups, who usually have to give their approval on matters of immediate concern to them, are more or less insulated from patients. Of those whose jobs include interaction with patients, those with the least control have the most contact with patients. As Table 3 shows, of those occupations which include contact with patients as part of the job duties (this excludes maintenance workers), the higher in the HVL hierarchy jobs are located, the more likely are their incumbents to have little contact with patients. Table 3 presents staff member contact with patients in terms of percentages with little contact by stratum in the HVL hierarchy.

Table 3.
Percentage With Little Contact by Stratum in the HVL Hierarchy

<u>Stratum</u>	<u>%With Little Contact</u>
	11%
Lowest	(n=44)
	29%
Middle	(n=17)
	33%
Highest	(n=6)
	16%
Total	(N=67)

In addition to the fact that a staff member's contact with patients is inversely related to his/her position in the HVL hierarchy, Gottesman and Bourestom (1974) observed that only about 2 percent of patient contact with staff involved skilled nursing. Moreover, they found that about 10 percent of the patients' time

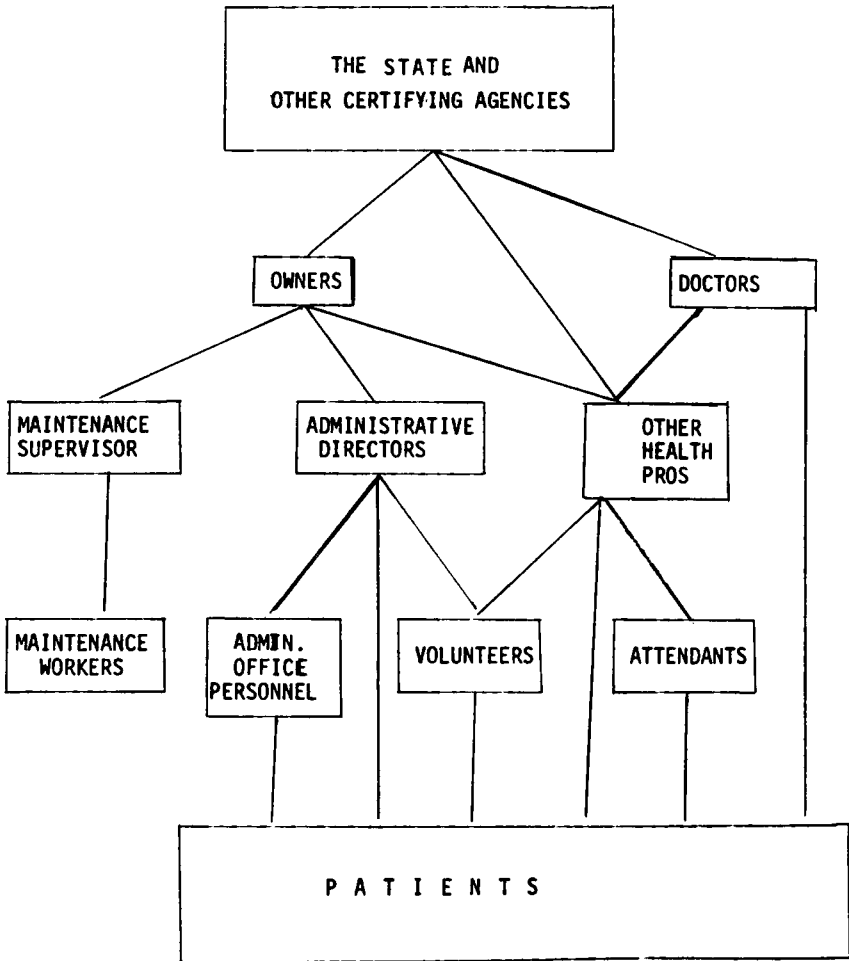
was spent in contact with any staff member. One could argue that this, at least in part, is also a result of nursing homes' drives for efficiency and a reflection of their for-profit orientation. For example, by using unskilled, low status, and low wage labor to deal with patients, costs are reduced and profits are increased. Moreover, these patterns of interaction can be explained by the power of higher ups to define who should and should not attend to the immediate day-to-day wants and needs of patients.

While higher ups, including the owners insulate themselves from patients, they, nevertheless, have access to and are accountable to funding sources. In the case of HVL, the major funding source is the state. Figure 2 diagrams the authority hierarchy at HVL. Under the current social organization, patients, who occupy the lowest stratum of the HVL hierarchy, have very little autonomy.

Barney (1974) points out the ineffectiveness of ordinary regulatory mechanisms in dealing with a service such as nursing home care, which has a relatively powerless people for a clientele. She goes on to warn that profit-oriented nursing homes, in seeking maximum efficiency and productivity, may take advantage of patients who cannot defend their rights. From this, it follows that the less powerful a patient is, the more likely is the staff of the nursing home to take advantage of him/her .

At times, the fact (or even the notion) that a patient is "confused" is used to disqualify his/her contentions. For patients at HVL, the process of becoming "confused" is often a labeling process in its most literal sense. Staff members (nurses, nurses' aides, and orderlies) meet weekly to discuss the eating habits, health statuses, moods, and behaviors of patients. In these meetings, staff members recount the behaviors of patients during that week, and patients are diagnosed as being "confused" in much the same manner that one would be diagnosed as being hypertensive. However, this particular diagnosis is more casual though it has more far-reaching consequences for the powerlessness of patients. For example, it often becomes convenient for the staff to deny certain charges and occurrences by simply saying that a patient is "just confused." While this label appears to fit some times, at others, the patient's claims are not just figments of his/her imagination. However, at this point, the

FIGURE 2.
CONCEPTUAL MODEL OF THE AUTHORITY HIERARCHY AT HVL



patient's claim is often a moot question to the extent that the label has been applied. This label in and of itself facilitates the powerlessness of patients, and often offers them no recourse but to accept injustices. So the accuracy or inaccuracy of the label is irrelevant; it is the unchallenged power vested in that staff to define who is or is not confused which is of consequence for patient-staff interactions.

At HVL, the question of patient power becomes even more clear-cut when money is involved: patients have virtually no say in such matters. Even when it comes to money which the patients own, the nursing home controls it. Patients may request their money, but will receive it only with the approval of the financial director or the owners, and only then if the financial director or the owners find the reasons given for the request acceptable. For example, one patient received \$50 from his brother. He said that he had had to turn this money over to the financial director. He asked me to go get it for him because he just knew that they would not give it back to him. I told a secretary in the business office of the patient's request. She referred me to the financial director. The financial director told me of all the paper work involved, asked me why the patient wanted the money, etc. However, she did refer me to one of the owners who happened to be there on that day. The owner told me that there was just too much hassle involved in getting the money to the patient for the reasons given. He tried to convince me that I was showing too much concern about how the patient would react. But finally, he told me that I could go out and buy whatever the patient wanted, and that HVL would reimburse me if I provided receipts. In this instance, the wishes of the patient prevailed, but only with the intervention of an outsider. What happens without such intervention is clear: The requests of the patient are ignored.

Moreover, because the staff can view most patients as nonpaying, incompetent, and/or unable to mobilize the resources necessary to having their claims respected, they (the staff) can ignore the requests of patients. Because the clientele at HVL are rarely immediately responsible for meeting the financial obligations to HVL themselves, the staff need not be very responsive to the complaints, concerns, or wants of the clientele. Moreover, at least some patients have problems with how their way is being paid at HVL, and the organization of payments in general.

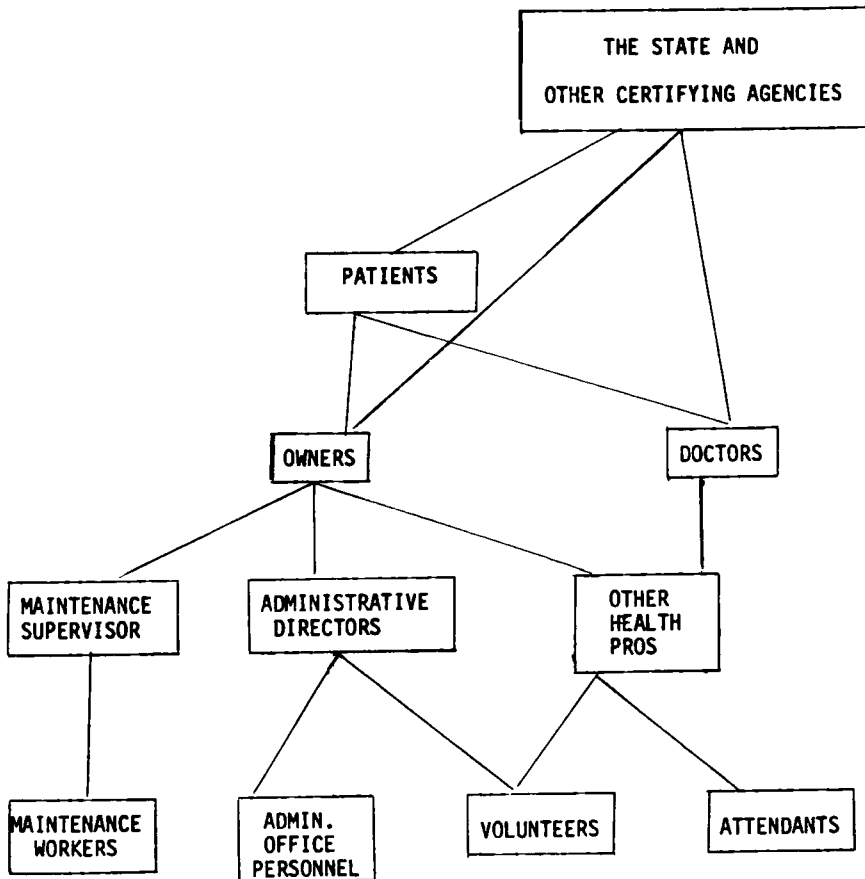
For example, one new patient was hesitant to eat a meal that was placed in front of her. She "knew" that the food was not hers because she had not paid for it. After a combination of persuasion, an increase in her hunger, and a few cautious looks at others eating, she ate, but not without continuously voicing her reservations about her inability to pay. In short, because the organization of payments is such that the cash nexus is hidden from patients, few of them assert their consumerism or look into alternatives; few of them feel like consumers or believe that they have viable alternatives to living in the nursing home. Thus, the nursing home staff need not view them as consumers, nor does the staff need be responsive to patient claims.

However, because of its profit orientation, Huron View Lodge is responsive to the complaints of the government and other sources of funding. Thus, it follows that HVL need be responsive to the demands of patients (only) to the extent that they are viewed as a real source of funding. The more patients are viewed as a source of funding, the more powerful they are, and more responsive the nursing home is to their demands. However, because the organization of payments is such that the government, not the patient, is seen as the source of funding, HVL can make profits at the expense of the state by minimally meeting the state's requirements and not necessarily those of patients.

The more direct funding the state gives to the nursing home, the less patients are viewed as a source of funding, and the less powerful patients are vis-a-vis others in the nursing home. In other words, the state facilitates the powerlessness of patients by granting funds directly to the nursing home. Instead of giving patients more power, which would substantially strengthen their position as consumers, the state often strengthens the position of the nursing home by offering it "cost-reimbursement packages" which protect it from risk of losses (Enthoven, 1977).

Figure 3 shows what the hierarchical structure of HVL might look like if the social organization were such that patients were given the following "power subsidies": (1) direct payments to them instead of to the nursing home, (2) the intervention of parties who are sympathetic to patients and who do not have to

FIGURE 3.
Conceptual Model of the HVL Hierarchy with Patient "Power Subsidies"



rely on the nursing home for funding, and (3) the provision of viable alternatives to living in nursing homes.

This diagram suggests a vast redistribution of authority (and thus in autonomy) in favor of patients. Instead of being the most dominated stratum of the hierarchy and being accountable to virtually everyone at HVL, patients would probably be more like real customers. Potentially, they would have more discretion in how their lives are lived. Theoretically, they, with the help of sympathetic allies, would have influence over the owners, to whom other staff members at HVL are accountable. To the extent that patient-staff relations at HVL are organized around money, they would be less subdominant to staff members. Most importantly, if need be, they would be more able to carry out their threats to leave the nursing home to find better living arrangements. The provision of alternatives would add substance to their threats of leaving.

In addition to the government, other groups can (potentially) affect relationships internal to the nursing home. As Barney (1974) points out, community presence is a key to improved conditions for patients. But as Newfield (1978) suggests, the media and the public have a limited span of attention when it comes to nursing homes. Only in the cases of scandal and horror stories is the public concerned. Such attitudes in the general society facilitate the patterns of interaction inside the nursing home. As Newfield (1978) points out, nursing homes become state-financed repositories of the old, the sick, and the handicapped because of lax governmental regulation, family and community noninvolvement, and unscrupulous, profit-seeking nursing home owners.

SUMMARY AND CONCLUSIONS

This research on the nursing home as a privately owned, profit-oriented, but largely state-financed institution was undertaken with the conviction that such research is important but more or less neglected. Most studies of nursing homes have looked at either the quality of care within the nursing home, or have addressed issues such as cost containment almost as if to separate them from what goes on inside nursing homes. For the most part, because of the nature of these studies, and the approaches they

have used, issues dealing with the quality of care and costs have been systematically separated.

However, because of the structural peculiarities of the nursing home industry which stem from the fundamental structure of American society, care of patients and other issues of staff-patient interactions must not be separated from what goes on outside the nursing home. This paper has tried to link the activities of nursing homes as profit seekers to federal legislation and the activities of strategically structured interests which seek to socialize their costs. Additionally, an attempt was made to show how factors which have their origins outside the nursing home have consequences for what takes place inside. Moreover, it was shown that those statuses which members of the nursing home entered with were associated with patterns of interaction and levels of control and authority within it. And finally, there was an attempt to show how government and community (non)involvement could potentially affect relationships internal to the nursing home.

As previously noted, the structural peculiarities of the nursing home industry (a "free-market," profit orientation while receiving funding from the state) have made it difficult to separate issues of cost-efficiency from issues of quality of care within these institutions. But the relationship between "costs" and "quality" are not necessarily as one would expect. Because providers of nursing home care are generally reimbursed for whatever costs they incur rather than on the basis of a standard rate, there is neither reward for cost-efficiency nor penalty for waste. Meanwhile, as profit seekers, there is little incentive for them to provide a quality of service beyond the minimum which will guarantee them a profit. For many other kinds of services, these issues of costs and quality can be resolved in the marketplace: people simply reveal their preferences by how they spend their money. But in the case of the nursing home industry, in which the state pays the costs of services provided, the nursing home is not overly dependent on those who make use of its facilities for its funding. Thus, it is not necessary for nursing homes to view patients as consumers who are to be satisfied. They only need to be responsive to the requirements of the state and have their beds filled in order to secure profits. In short, under the current organization of payments, nursing homes can make

profits at the expense of the state by only minimally meeting the state's requirements (and not necessarily those of patients who make use of these services).

The problem of public policy design is to define the appropriate role for government to achieve desirable social purposes most effectively. If a desired goal is to improve the quality of life for the elderly, the sick, and the handicapped while reducing (or at least containing) costs, and if it is not (necessarily) desirable to increase the profits of nursing home owners, then clearly the strategy currently in use is flawed. To correct this, the government must provide more alternatives (such as community-based adult day care, home health care services, homemaker services, and communal living arrangements) to those who would usually end up in institutions. A threat is only as good as its ability to be carried through; therefore, it is up to those on the outside to make sure that a patient's threat to leave the confines of a nursing home can be acted out if necessary by making provisions for alternatives. Direct payment, as opposed to the current organization of payments, provide the potential for alternatives to those who might seek them. For those who do become institutionalized, the state and others can facilitate their receiving better quality treatment by insuring that nursing homes become not only for-profit, but also for- service-oriented.

NOTES

¹Staff members with little control are those who have no supervisory nor policy-setting duties as part of their jobs; staff members with much control are those who do have supervisory and/or policy-setting capacities as part of their jobs. Because of the research methods employed, all data statistically analyzed are "objective," i.e., coded according to observable (nonattitudinal) criteria.

²Rather than just detracting from the explanatory powers of Table 2, the existence of zero cells adds substantively to the meaning of the table and gives greater insight into the power relationships in the nursing home; that is, it is shown that there is no such thing as a black male with professional status at HVL.

Moreover, there are no black males at HVL who have much control. Conversely, there are no white males who hold positions with professional status and do not have much control. All professionals, except for some of the white females, have much control in this setting.

³A logit analysis of Table 2 (not presented here) indicates that professional status, race, and sex are all related to one's level of control at HVL. There is an interactive effect for professional white females which predicts that they will have lower levels of control than other professionals in the nursing home setting. When one statistically controls the simultaneous effects of these variables, the following coefficients and equation result:

$$\text{Log Odds (Much Control)} = \left(\frac{\pi}{\sqrt{3}}\right) \times (-2.55 + 1.89_{\text{STATUS}} + 1.51_{\text{RACE}} + .60_{\text{SEX}} - .98_{\text{INTERACTION}})$$

when

STATUS= 1 Professional
 0 Otherwise

RACE= 1 White
 0 Otherwise

SEX= 1 Female
 0 Otherwise

INTERACTION= 1 White Professional Female
 0 Otherwise

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