Reward Structures and Organizational Design

An Analysis of Institutions for the Elderly

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This article is concerned with the issues of motivation and control of nursing home personnel to increase their responsiveness to the needs of the elderly. The perspective taken is one of organizational analysis and, specifically, a consideration of the functions and dysfunctions of particular reward structures. The reward structures analyzed are (1) reimbursement schemes for homes in relation to the performance of home administrators and (2) supervisory arrangements for personal care workers in regard to the delivery of nonroutine services to patients. We point out some of the difficulties inherent in existing organizational structures and suggest modifications to increase the influence of patients and their relatives.

The configuration of rewards is one of the two mechanisms by which performance is motivated and controlled in formal organizations, the second of the mechanisms being the socialization process. By "reward structure" we mean the array of inducements and punishments associated with different levels of performance. By "socialization" we refer to the internalization of values

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concerning what constitutes suitable role behavior. In this article we shall use the concept of reward structure as an integrating theme; several features and problems of nursing homes will be outlined in reference to this framework.

Sociologists commonly investigate how the characteristics of individuals influence performance with respect to the operation of *a particular* reward structure. For example, there have been many studies of educational achievement, the rewards in this instance being class grades. Some of the factors found to differentiate among students are IQ, race, parental socioeconomic status, and parental values (Hauser, 1971; Coleman, 1966). There also have been numerous studies of attainment within work organizations; here the relevant rewards are occupational status and earnings. The basic finding is that family background, educational attainment, sex, and race make a substantial contribution to explaining individual differences in occupational achievement (Blau and Duncan, 1967; Jencks, 1972).

Less attention has been given to the subject of *how to structure* rewards in a particular institution in order to motivate performance. We have ample evidence that features of the reward scheme are consequential for individual behavior. For example, students appear to learn more when letter grades are awarded than when a pass-fail system is used (Gage and Berliner, 1975: 341-342). Similarly, there have been investigations of attainment in the classroom when concrete, rather than symbolic, inducements are offered (e.g., monetary reinforcement instead of grades) and when group performance, rather than individual merit, is reinforced (Spilerman, 1971: Johnson and Johnson, 1974; Michaels, 1977; Slavin, 1977; Slavin and Tanner, 1979). We learn from this literature, for instance, that concrete inducements are more effective than symbolic rewards at an early age and for lower-class and minority youth—in short, for students who have not internalized the value of education. Where internalization has taken, symbolic rewards appear to provide adequate motivation.

Different kinds of reward structures are also used by work organizations. Firms may remunerate employees on the basis of a piece rate, an hourly wage, or a weekly salary, the choice depending on the type of product and the style of supervision. Still different reward structures, such as the Scanlan plan (Brown,

1965), provide a bonus for *group* productivity. It is recognized that these different reward structures sensitize employees to particular facets of their work roles. Piecework is the extreme case of reward for uncoordinated effort (though, as we have learned from the Bank Wiring Room study [Roethlisberger and Dixon, 1940; Homans, 1950], informal peer pressure may operate to reduce the variation in individual productivity that would exist among isolated workers). In contrast, group-based payment plans ensure a maximum amount of cooperation and are effective schemes when coordination is required.

Where tasks are complex, an appropriately designed reward structure will be multifaceted. For example, it is not unusual for a worker's wage rate or promotion prospects to reflect his individual performance while, at the same time, bonuses are offered to the work group for high productivity of completed units—a task that may require coordination. To incorporate a firm's concern about work quality, the remuneration plan might count defective units against the group's bonus.

It is also recognized that a reward structure can be ill-designed. A common example concerns the tendency in some organizations to reify "procedure" when deviations from the rules are necessary for goal attainment (Davis, 1948). Individuals go by the book, in this circumstance, not because they are psychologically compulsive, but because the reward structure is more sensitive to means than to achievement. Initiative is suppressed and "ritualistic behavior" replaces "goal orientation," to use Robert Merton's (1957: 131-150, 195-202) terms.

Another way in which a reward structure can be poorly designed is if it is not adequately sensitive to relevant constituencies. For instance, governmental agencies intended to serve the public sometimes are unresponsive to client needs (see, e.g., Blau's, 1960, analysis of welfare departments). What can be responsible is an arrangement whereby clients have little power in their dealings with staff because client satisfaction is not consequential for the careers of the workers. In contrast, in the private sector, customer treatment usually is superior. Since customers can take their business elsewhere, a decrease in patronization constitutes feedback to a firm that something is amiss. If the problem is correctly diagnosed, staff rewards will be adjusted to

reflect perceived relations with customers. In short, the adaptive mechanism within firms in a competitive economy recognizes that customers have power and the reward structure of employees is organized to reflect this fact.

The above comments are intended to convey the meaning of reward structure, the importance of this concept, the fact that different designs can exist for a given institution, and the point that a reward structure can be sensitive to certain aspects of organizational operation—or to certain constituencies—but can ignore others. To complete this discussion, we point out that in a *total institution* (one in which individuals reside involuntarily and have little control over the elements of their lives), the significance of the reward structure is magnified, since there can be neither withdrawal from the facility nor appeal from its internal arrangements (Etzioni, 1961: 160-174). Where the preferences and dissatisfactions of residents can be ignored, these persons are effectively powerless. The pathological forms of behavior that arise in this setting (infantilism, identification with aggressors) are well-documented (Bettleheim, 1943, 1967: 63-68).

A second integrating theme of this article concerns the tension between the dual goals of efficiency and responsiveness. In a nursing home, efficiency is promoted by routinization of care and by the creation of categories of patients, so that specialized mixes of services can be tailored to homogeneous groups of residents. With respect to routinization, a major difficulty is that many personal needs of patients cannot be scheduled, and attempts by a home to impose such an order tend to be burdensome for the residents. With regard to categorization, which is accomplished according to disability level, this attribute is not stable, so that the maintenance of relatively homogeneous nursing care categories entails the shifting of residents between wards and institutions. Thus, the strategies which are normally applied to obtain efficiencies in a work organization can, in a nursing home, undermine the quality of personal and social life.

In the next section we describe state reimbursement schedules for nursing home expenses and the implications of the reimbursement scheme for patient welfare. Following these comments, we turn to the matter of relations between nursing home personnel and residents and inquire into the consequence of particular

supervisory patterns for the quality of the interactions. In those two sections the underlying theoretical theme emphasizes the structure of rewards and the dysfunctions of particular existing arrangements. In the third section we shift to a consideration of efficiency and responsiveness from the perspective of organizational structure and organizational design.

As a final note, we point out that a principal source of information about the daily operation of old age and nursing homes was our own unsystematic observation over several years in four highly regarded institutions. Our presence was as relatives of patients and our attentions were directed toward their needs, not to comprehensive data gathering with pretested instruments. Yet, this sort of involvement exposes one to rather subtle aspects of decision making in the homes and to the nature of interactions between staff and patients. Our confidence in these observations is heightened by the fact that, independently, we reached many of the same conclusions.

Reimbursement Policy and Nursing Home Adaptations

ALTERNATIVE REIMBURSEMENT SCHEMES

Reimbursement policies for *hospitals* commonly follow a fee-for-service arrangement. Charges to a patient or a third-party provider reflect the cost of diagnostic tests, treatment, drugs, and other services provided to the individual. To be precise, there usually is a fixed charge for room, food, and routine nursing care, which varies only according to the type of room accommodation (e.g., private or semiprivate). The cost of supplementary procedures is added to the basic bill.

One exception to this arrangement is that the daily rate in the intensive care ward is higher than the rate charged in other hospital units. Thus, we can view a medical facility as containing two (or more) categories of patients, with different daily rates for each. All patients within a category are billed the same fee, aside from charges for individual medical procedures. The latter, however, constitute a substantial portion of a patient's bill; indeed, often this is the larger amount.

Nursing homes for the elderly and old age homes tend to follow different reimbursement models. The majority of *old age homes* receive payments directly from residents or their families, not from third-party providers. Retirement homes, consequently, are able to organize their charges in a variety of ways and appear to respond to the market with regard to fees billed and services provided. Nonetheless, most operate as sheltered hotels of one sort or another and charge a fixed montly amount which covers room, food, and ancillary services such as entertainment. Like a hospital's daily rate, the amount is usually a function only of room choice. Unlike a hospital, there is little variation among residents in the cost of their care and hence no need for supplementary charges.

Nursing homes operate within a more constrained reimbursement environment. For most homes, the major source of income is third-party payments, especially Medicaid, and nursing homes therefore operate in accordance with regulations that qualify them to receive these reimbursements. Although the governing provisions are state rules, because the source of the funds is federal moneys, the regulations vary little from state to state in many essential respects. Congress requires each state to reimburse nursing facilities on a "reasonable cost-related basis." Federal legislation is also responsible for the creation of two categories of nursing home patients, "intermediate care" and "skilled nursing care."

The logic behind establishing levels is to promote efficiency by permitting different bundles of services to be provided to each group. The distinction between the two categories involves, more or less, a consideration of whether a patient is ambulatory, alert, and needs only minor assistance in dressing and washing or whether a higher level of care is required. In most states, like a hospital's basic room charge, the fee to a resident—or to a third-party provider—is the same for all patients in a category. Unlike hospitals, this fee is the principal charge levied by a nursing home for its services, irrespective of the needs of a particular patient.

States do differ in details of the reimbursement scheme. Some employ a system in which the fixed amount charged for each patient in a category is established prospectively, at the beginning of a billing period. Others compute payments retrospectively, on

the basis of actual allowable costs. Most states have adopted "facility-related" reimbursment plans, in which state payments are based on the costs incurred by the particular home. However, a few (e.g., Illinois) use "facility independent" reimbursement schemes, in which payments are tied to patient characteristics and to the services offered by the home (Holahan et al. 1977: 106-113). A very few (e.g., California) use versions of "flat-rate" reimbursement, in which the payment is identical for all patients in a category in every nursing home in the state (Spitz and Weeks, 1980a: 28). Nevertheless, because all states set maximums on the per-diem charges they will accept, the opportunity to recover high expenses—even when properly incurred—is limited under any of the arrangements.

NURSING HOME RESPONSES TO THE REIMBURSEMENT STRUCTURE

The reimbursement schemes under which most homes operate were designed with the objective of controlling costs, especially costs billed to third-party programs. Nursing homes have some discretion concerning how they choose to limit costs, though they must meet state licensing standards in regard to details of the physical facility, food quality, availability of registered nurses, doctors, and the like.

The criteria that homes must meet are, effectively, features of the reimbursement structure that cannot be ignored by home administrators. Existence of a minimum standard for licensing establishes threshold adaptation behavior for a profit maximizer: Do enough to safely exceed the mandated minimum, but no more than necessary. Some states (e.g., Connecticut and Illinois) have complex reimbursement formulas, which depend on home quality. In Connecticut, institutions are graded A, B, C, and so on in accordance with a variety of phsysical and service characteristics, and the per-diem reimbursement rate increases with a home's quality score (Moss and Halamandoris, 1977: 142). This arrangement constitutes a prescription for a nursing home administrator regarding the improvements he might make in order to increase income. More important, schemes of this sort also designate—by omission—the features of homes and the array of potential

services that will *not* enter into the reimbursement calculations.

The criteria that receive weight in the evaluation of a home for licensing, or in the determination of its reimbursement rate, have characteristics of being (1) quantifiable and (2) health related, rather than "quality of life" indices. Quantifiable standards are preferred because they usually are objective, unambiguous, and replicable. Health-related criteria are emphasized because the nursing home, as a social institution, has been viewed more as an adjunct of a hospital than of an old age home (Kane and Kane, 1978). Also, while the efficacy of health-related regulations for patient well-being can be documented, this is more difficult to accomplish with "quality of life" programs. Thus, nursing homes are likely to have requirements about nutrition, room temperature, and bathing of patients, but not about the provision of social or recreational activities. Because administrators respond to the inducements of this reward structure, one often finds the physical needs of patients adequately cared for, but in an environment that is sterile—socially, intellectually, and emotionally.

The different reimbursement schemes we have enumerated provide inducements for particular sorts of dysfunctional adaptations. As a general statement, *facility independent* reimbursement encourages threshold mentality among administrators: On each activity covered by the state, spend enough to ensure home accreditation for the activity but no more, since actual costs do not enter into the reimbursement formula. Where homes are paid on the basis of a patient's assessed level of disability (e.g., Illinois), there is little incentive for encouraging patient improvement since this would reduce income. Flat rate reimbursement is even more pernicious from the point of view of patient welfare: Each dollar spent on a patient comes out of the home's potential profit (Vladeck, 1980: 83-86).

Facility dependent reimbursement carries little motivation to control costs because these can be passed on to the state. However, this is really a theoretical assessment, since in practice all states have a cap on the expenses they will reimburse.[1] Further, states using a facility dependent scheme have been moving toward *prospective* determination of the rate as a way to control costs. Like flat-rate reimbursement, this creates a zero-sum relationship between a home and its patients: Once the rate has been set for a

year, each dollar saved can be retained by the home. Thus, an incentive is created to reduce expenditures, possibly to the detriment of patient care.

Facility dependent reimbursement with prospective determination of the rates is the most widely used arrangement. Where we do not note otherwise, we will be commenting on this reimbursement structure. We wish now to describe a couple of concrete adaptations which are rational for nursing homes to make and which, from informal discussions with staff, we believe they do make. We point out that our comments are based on observations in a few homes, though we suspect that the adaptations are fairly common (see, e.g., Spitz and Weeks, 1980b: 46; Dunlop, 1979: 89).

Admission Decisions. If patients are divided into two categories—intermediate care and skilled nursing care—and if the per-diem rate is the same for all patients in a category, then, on economic grounds, nursing homes should prefer the less infirm applicants from among those who qualify for a particular level of care category. While the degree of a patient's disability affects the amount of assistance and the resources he will require from the home, the per-diem billing structure is not sensitive to this consideration once the rate is set for the year. Such calculations may not be pertinent to homes with many vacant beds. However, the better institutions have waiting lists and are tempted to make cruel distinctions among the elderly, in which those with the greatest needs are disadvantaged in their quest for entrance.

Who shall live? Nursing homes for the elderly often are terminal residences for this population. The length of stay tends to be long, in comparison with hospitals; in 1973, for example, the average stay in a Medicaid-certified skilled nursing facility was 20 months (Kane and Kane, 1978: 914). Among the elderly, the final years of life are accompanied by strokes and progressively incapacitating infirmities. As a result, the admission decisions of homes usually bear relevance for the level of patient needs and patient costs only during the initial months of a stay.

In a nursing home, then, patients soon come to differ greatly in the amount of resources they require in order to be sustained. In a

skilled care unit, the range of infirmity can vary from individuals who need only to be assisted from bed and dressed but are mobile with the aid of a cane or walker to patients who are paralyzed and require extensive assistance. There may also be language impairments which slow communication with a nurse or orderly, thereby requiring more staff time.

It is our view that administrators of nursing homes, at least implicitly, utilize a form of triage in allocating institutional resources. One group of patients is "profit making" from a home's point of view, in that they require less staff time and fewer resources than the funds they bring into the home through the fixed per-diem reimbursement. A second group requires resources in an amount roughly commensurate with the funds they bring to the home; the institution "breaks even" in providing for their needs. Finally, because of the range of patient infirmities within a single reimbursement category such as skilled nursing, there are individuals who require attention and resources in excess of the income they generate.

Now, the fact that, from time to time, a resident may require large expenditures by a home for brief durations—such as when one becomes ill with an infection—is unimportant with respect to the commitment of the home to maintain him. Rather, it is the patient who *chronically* requires a large outlay of nursing time, such as a paralyzed person, who is a threat to the economic viability of a home. Proper care may necessitate feeding, washing, turning each hour to avoid bedsores, and frequent changing of bedsheets. The high expense of nursing care for such an individual cannot be recovered under a reimbursement structure which is insensitive to patient differences in the cost of maintenance.

The adaptation which we believe occurs is that the resources required by these patients in order to survive in modest comfort and health are often denied to them. We are not alluding to the decisions of insensitive owners of profit-making homes, the scandals which have appalled us in recent years. Indeed, we suggest that in the best institutions, out of concern for the welfare of *all* residents, administrators limit the resources they permit to be spent on a chronically infirm person. The rationale is a humanitarian one: Resources expended on one patient are not

available for others. At stake is not a simple moral decision of whether to meet an invalid's many needs versus maximizing the return on a financial investment, but a question of balancing the competing requirements of many elderly persons who must be maintained on a fixed budget. The result is cruel, as administrators invariably opt to care for the many, with the result that paralyzed though alert patients have to wait intervals for assistance which exceed their endurance.[2] The psychological and physical deterioration caused by this neglect is extensive.

One way in which administrators implement their decisions regarding the allocation of resources among patients is by assigning a fixed number of personnel to each ward, with responsibility for all patients in the jurisdiction. Incapacitated persons may receive more staff time than other residents, but usually not an amount commensurate with their needs. Just as a home administrator must make a decision about distributing the institution's limited resources among patient wards (which he makes, in part, through staff assignments), service personnel need to decide how to allot their scarce time among the assigned residents. To emphasize the difference with a hospital, the recourse of adding staff to care for patients with severe incapacities is not an option chosen by a nursing home when these expenses cannot be recovered.

A related issue concerns the provision of medical treatment in cases of acute illness. Small nursing homes do not employ a medical staff; rather, a patient's own physician visits the institution in times of sickness. A question can arise concerning when to transfer a resident to a hospital. A home's interest in this matter is that, in several states (e.g., New Jersey), reimbursement stops once a bed is vacated and it can be several days until a new resident is admitted. Where a physician obtains referrals from nursing home administrators, he may in turn respond to the home's preference regarding transfers, except for the most serious of illnesses.

Large homes often employ full-time physicians. This ensures the ready availability of medical personnel, but it also carries a potential for conflicts of responsibility. As an employee, a staff phsyician must be sensitive to the home's wishes on medical-related matters. Moreover, staff physicians often are foreign

nationals or immigrants, without a realistic option to enter private practice; this structural position serves to further undermine their professional autonomy.

To limit costs, homes may discourage physicians from prescribing procedures that entail intensive nursing, to the detriment of an ill resident. Also, even with physicians on staff, a nursing home has a limited capability for treating severe illness. (They may not have the facility, for example, to do IV's or monitor a heart's rhythm.) Yet, aside from a home's interest in avoiding empty beds, hospital transfers are inhibited by the fact that the justification to the state for employing physicians may involve an understanding that many illnesses, which otherwise would require a hospital stay, could be treated locally. These comments pertain to the care of any acutely ill resident but they are especially relevant to severely incapacitated patients, for whom a decision to trate aggressively or not carries implications for the long-term financial situation of a home.

These considerations lead to the topic of how to organize nursing homes so that they will be economically efficient *and* responsive to a patient population with a variety of needs. From what we have indicated, residents who have severe infirmities suffer acutely under the present reimbursement arrangement. One approach would be to devise entirely new reward structures. An interesting recent proposal (Kane and Kane, 1978) would have homes reimbursed according to the time course of a patient's level of functioning, in relation to his prognosis at the time of entry into the institution. This scheme has the advantage of eliminating the incentive to skim healthier individuals from the applicant pool. It also would associate the payments that are received by a home with patient welfare.

Yet, there are practical difficulties with a reimbursement structure of this sort. It would place a heavy responsibility on obtaining accurate assessments of patient functioning at the time of entry into the institution and at subsequent time points. Because of day-to-day fluctuations in the condition of elderly persons, multiple observations would be required at each assessment to construct reliable evaluations. It also would be necessary to devise a measurement instrument that is replicable across

investigators because the same specialist might not be available to examine a patient at each follow-up. Adding to these problems is the necessity for having the evaluations performed by specialists who are independent of the nursing home, since financial payments to the institution would be at stake. Still further difficulties involve the construction of accurate forecasts of individual functioning and the factoring into the reimbursement model of adjustments for unpredictable events—strokes, broken hips, and so on. In short, the complications associated with managing this reward structure would be immense.

A less ambitious approach would be to tinker with existing reimbursement plans, making modifications once information has accumulated concerning specific dysfunctions. For example, even with the structures currently in use, homes could be made more responsive to patient needs by creating additional resident categories, each dedicated to a particular type of infirmity or level of care, and each having a reimbursement rate appropriate to the cost of its services. A very different sort of strategy is based on the recognition that no simple reimbursement plan is likely to be devised for a complex institution, such as a nursing home, without incentives being present for some kinds of undesired adaptations. Following this reasoning, a recommended course would be to supplement the control functions of the reimbursement structure with monitoring programs and feedback channels to concerned constituencies, who might intervene to safeguard patient interests. Ombudsmen and relatives' associations can play important roles of this nature. These options are outlined and appraised in the next sections, in connection with other nursing home issues.

Interactions Between Staff and Patients

THE STRUCTURAL CONTEXT

The staff we are concerned with here are the workers who have greatest impact on the day-to-day affairs of residents—nurses' aides and orderlies. One must first appreciate what their work is like. It consists of feeding patients, turning and washing them,

inserting bed pans, cleaning bed pans, and helping patients to the bathroom and wiping them. One must next understand who the workers are. Because of the nature of the task and the fact that the jobs are "dead end," the workers tend to be individuals with little education and low motivation. In large cities, they often are ethnically and racially different from the residents; in New York City, for example, the lower level staff are, predominantly, black and Spanish-speaking, while the residents are middle-class individuals of Jewish, Italian, or Irish descent.

Finally, one must recognize that the conditions of most patients make interaction with staff—especially expressive interaction—exceedingly difficult. Many elderly persons have speech or hearing impairments, as a result of stroke or degenerative illness. Others are marked by some degree of senility. These maladies coupled with the fact of class, ethnic, and sometimes language differences virtually eliminate the possibility of empathy, affection, and personal consideration emerging in the relations between patients and workers.[3] This social gap is consequential because, in a context of minimum staff socialization to notions of societal responsibility for the elderly, an absence of personal bonds to moderate staff behavior means that the only mechanism available to administrators for influencing performance is the reward structure. It is our contention that the reward structures currently in effect do not adequately motivate or control staff behavior.

It still remains to point out the enormous importance of lower level staff for patient welfare. Doctors and nurses may visit patients intermittently, but they do not respond to the hourly needs of the residents. Patients are dependent upon aides and orderlies for assistance with the everyday tasks which make existence possible. How the assistance is provided determines whether or not an infirm person can live in modest comfort with some control over his immediate environment. This dependency translates into staff power. A patient who is viewed as troublesome may have to wait a long time for service. Since the degree of control over bodily functions is limited in this population, a 10-minute wait can be beyond endurance. Because there are no alternate suppliers of these services in a nursing home and because patients reside there continuously, rather than for part of

each day, nursing homes are effectively "total institutions" (Etzioni, 1961: 160-174); in an organizational sense they share important features in common with prisons and concentration camps. In each setting, residents are dependent upon staff for the essentials of their existence, powerless in their dealings with staff, and unable to withdraw from the institution.

Low-level workers have enormous power over resident comfort for several reasons. First, the staff are overworked and competing requests frequently are made for their time. As a result, failures in responding to a patient can be explained to a supervisor in terms of the concurrent needs of other residents. Second, complaints are often discounted, attributed to senility or to diffuse patient anger at their own physical incapacities, which is displaced upon staff. Third, many patients have little sense of time and do confuse a 5-minute wait with a 20-minute delay. This situation is exploited by service workers, who explain genuine complaints in terms of patient disorientation. Lower level staff are especially powerful during the night shift, when few supervisors and no relatives are present. Finally, where the staff is unionized, it is difficult to discipline a worker in response to patient complaints unless physical abuse is evident. Disciplinary hearings involve a fact-finding procedure and, because of the mental haziness of many patients, their testimony is suspect.

Staff use their discretionary power to acquaint patients with proper behavior (from the workers' perspective), to reduce patient expectations and thereby limit the demands for staff time. When a new resident arrives at a nursing home, relatives are discouraged by low-level workers from visiting frequently, even though the home's announced policy may encourage such visits. In a manner reminiscent of children arriving at summer camp, relatives are told that new patients resist adjusting to institutional life, that frequent visits by relatives inhibit a patient's interest in befriending other residents and slow his acclimation to the home and its activities. There is merit to these remarks, but they are also self-serving: It is in the interests of staff that new patients be taught to accept long waits for service. They must be introduced to the power of workers to discipline, to respond to or ignore requests, and must learn that complaining to a supervisor is of no avail.

The reaction of new patients who are mentally alert is one of frustration, anger, and protest at this loss of control over the elements of their existence. In the initial weeks of stay, relatives are a problem for staff, since new patients may request concerned relatives to intervene and, unlike residents, relatives are not powerless. However, if frequent visits can be discouraged during the adjustment period, a new patient's expectations can be altered and brought into line with the facts of life in the home. In a total institution, the impact of behavioral modification is enormous and few insist for long on their abstract rights.

When a patient is not severely impaired, staff socialization can make him self-reliant, since worker interests are not directed to limit a patient's activities but to reduce the demands made upon themselves. However, when a patient does require considerable assistance, the socialization process tends to leave him depressed and demoralized, because his dependence upon staff convenience and schedules is made evident. A resident who cannot control his bodily functions will hear comments such as, "You just had the bed pan, you must wait a half hour" and "even though your bed is wet, I don't change linen until 2 p.m." Socialization makes the impaired patient compliant with such directives, but the adjustment can be devastating to his or her self-esteem. It is not uncommon for the range of interests of an alert and sophisticated individual, in this situation, to become constricted and focused on concerns about meeting toilet schedules.

MODIFICATIONS OF THE REWARD STRUCTURE AND OTHER OPTIONS

The problem we have delineated arises from the concentration of power over patient welfare in the hands of low-level staff—hardly the most qualified of individuals—and the absence of countervailing controls to protect patients from neglect or abuse by the workers. All remedies of this situation involve a rebalancing of the power relationship, giving patients or their guardians an opportunity to evaluate staff actions and provide effective inputs to their reward structure.

A direct approach to strengthening the hand of residents would be to have home administrators collect from them ratings of the

performance of each worker. This is feasible, since the patients would not be evaluating staff in terms of technical expertise but in terms of courtesy and responsiveness. A question can be raised with respect to the interests of nonalert patients, who could not participate in an evaluation. Yet, the problem of staff performance, and their responsiveness to requests for nonroutine service, is mainly a concern of alert residents. Nonalert patients would continue to be served by the routine procedures mandated by the home. A more serious difficulty stems from the fact that residents cannot be neatly divided into alert and nonalert categories; many even vary from day to day in degree of mental clarity. For this reason, reliance could not be placed on the ratings by any single patient. However, where there is consistency in the evaluations of a worker, the result would carry greater reliability. Even more consequential than an analysis of the ratings would be the act of collecting such information. We suggest that once the staff recognize that residents will be queried periodically about worker responsiveness, this fact itself would moderate their behavior.[4]

Most homes forbid tipping. This prohibition is a testament to the effectiveness of tipping in influencing staff activity. A relative can obtain remarkably considerate service for a resident by passing a few dollars to an aide and letting him know that more will be forthcoming if a favorable report is provided by the resident. Tipping is forbidden because it would disrupt the home's control structure. It would distort the staff's allocation of time among patients, favoring those with external resources; it also carries a potential for extortion from patients or their relatives.[5] Yet, incentive rewards can be managed so that they do not produce these undesired consequences (see, e.g., Sand and Berni, 1974). For example, a sum could be allocated to each worker on the basis of his average rating by the patients. Also, the allocations could be made to groups, rather than to individuals, so that the workers would be motivated to cooperate with one another in providing for patient comfort.

As an interested affiliate of a nursing home, a relatives' association can increase the sensitivity of the institution to the behavior of its staff. Home administrators recognize that many kin are concerned about patient welfare and collaborate with

relatives' associations to the benefit of the residents. Yet, the objectives of relatives are not identical with those of home administrators; a potential for conflict exists, for example, over issues such as when to transfer ill residents to a hospital and how much conformity with a home's routine should be expected of residents. In dealing with administrators, relatives are at a disadvantage because they usually lack information about events in the home. They are not in a position to evaluate the complaints brought by patients or to challenge the explanations offered by the institution. To be effective, relatives require a source of independent information about a home's daily operation. We suggest that this could be provided by a hired representative, whose task would be to listen to complaints, observe staff behavior, and report on these matters to the relatives' association. With access to such details, the affiliate could document the insensitivities of individual workers and, generally, intervene on behalf of patient interests. For this sort of arrangement to work, it is vital that the hired observer be responsible solely to the relatives' affiliate and that his assessments not be diluted by the facility's view of its problems and requirements. We are therefore skeptical about the capacity of ombudsmen (who are state employees) to effect changes in a home's operation which require continuous monitoring and the focused resolve that few but concerned relatives can provide.

Each of the preceding approaches represents a different tactic for strengthening the hand of patients in their dealings with staff. In a well-governed home, the administrative structure can ensure adequate delivery of routine care; what remains problematic is the performance of tasks which cannot be scheduled and which must be carried out in response to patient requests. It is our view that the schemes we have enumerated complement one another, in that each permits staff behavior to be evaluated from a different perspective, though one in which the intention is to increase the influence of residents. We also favor a general strategy of redundancy in the mechanisms which protect patient interests because their great dependency upon staff leaves patients very vulnerable.

Organizational Design

TYPES OF HOMES

For the purpose of understanding some of the anxieties of elderly persons in relation to nursing homes, it is useful to broaden the range of institutions under discussion. Old age residences often are analyzed separately from nursing homes, yet in the minds of many aged individuals, the two sorts of facilities are not very different; sometimes homes of each type are even linked together organizationally.

The reason why old age homes and nursing facilities are discussed separately is that, as social institutions, they differ in a number of significant respects. Old age residences are technically simpler; they require less capital investment, a lower level of medical skills, and utilize fewer workers. Patient needs in a nursing home are more extensive, and the complex licensing regulations of nursing facilities derive from this fact. Also, the source of income is different: Old age residences receive mainly private payments, while nursing homes obtain a major portion of their funds from third-party providers. For these reasons it makes sense to discuss the two institutions separately; each has its own sorts of problems and has developed a form of organization suitable to its objectives and financial environment.

What is missed by this characterization is the fact that extensive patient flows occur between these types of facilities. Old age home residents are transferred to nursing homes if their condition deteriorates, perhaps with a hospital stay intervening. Conversely, individuals whose first residence in an institution for the elderly is a nursing facility may recover sufficiently to be moved to an old age home, though not to a point where they can return to a private residence. One difficulty posed by these flows is that the framework of residential institutions for the aged is not arranged in a way that is sensitive to the consequence of such moves for the social and emotional well-being of elderly individuals.

According to Scanlon et al. (1979: 61), in 1973, 72% of *old age homes*[6] had fewer than 25 beds. The institutions which we

observed are much larger; each has separate rooms for about 150 residents. Meals are served in a dining room, which is not unlike a comparable facility in a hotel. Some recreation activities are scheduled each week by the homes; beyond this, the residents have abundant time for conversation and leisurely contact. Yet, in our observations, and according to others (e.g., Riley and Foner, 1968: 587), the density of social interaction in an old age home is low. To some extent, this is attributable to the impairment of mental capacities in this population. However, social distancing also appears to arise from the high rate of unscheduled departures from a home.

Sudden death is not an unfamiliar event in this age group, so one is hardly stunned to learn at breakfast that a coresident passed away during the night. Yet, incapacitating illness is far more common and one may hear each week about several neighbors who have been removed to a hospital or a nursing home. While many of the departers recover, or at least stabilize at some higher level of infirmity (e.g., an inability to walk), they rarely return to the old age home they left, especially if the institution is well regarded and has a waiting list. One reason is that full payment for room and meals is required to keep a room available, and this can be financially prohibitive if the recovery period extends over several months. An equally consequential reason is that old age homes will not admit individuals who are even mildly incapacitated; applicants must be able to dress and care for themselves. Most homes will not accept a person who requires a wheelchair or even permit a resident who deteriorates to this level to remain.

The above remarks were intended to describe an environment in which one's friends and acquaintances are prone to disappear suddenly. The psychological adjustment made by many elderly persons to this situation is to avoid establishing close friendships since, all too frequently, the consequence of intimacy is the pain of loss. Partly for this reason, old age homes appear to an observer to be places characterized by high levels of social isolation—while close physically, the residents are very separate emotionally.

Even more anxiety-provoking than the fear of loss of friends and acquaintances is the prospect of becoming ill oneself. Because

transfer to a hospital or a nursing home carries a significant probability of not returning, one's familiar surroundings and social environment are threatened. Illness not only means physical pain and mortal danger but also can be cause for "expulsion." If one's ability to walk becomes impaired even slightly, this can generate great psychological distress. An unsteady gait is visible to staff and to other residents, and all know that further deterioration may require the individual to leave.

As a result, the organizational and physical division of institutions for the elderly into old age homes and nursing facilities is a cause of anxiety for elderly persons as it requires moves that are disruptive of social linkages. The different costs of entry into the two markets, the different organizational arrangements and sources of payment, make the tendency to specialize in one or the other type of facility an understandable decision. Some authors (e.g., Penchansky and Taubenhaus, 1965) have even recommended more extensive differentiation among homes, on the grounds that programs and resources could thereby be effectively targeted to the specific needs of residents in each facility.

One way to retain the advantages of specialization and yet reduce the trauma produced by the present organizational structure would be to promote the building of large institutions which have the scale to include both a sheltered residence and the two categories of nursing home care. An alternate approach would be to encourage vendors of smaller facilities, which provide complementary sorts of care for the aged, to locate on adjacent sites. Such arrangements (which could be promoted through tax incentives) would permit elderly individuals to continue living in the same social context as they pass through the stages of later life.

CATEGORIES OF PATIENTS; CATEGORIES OF WORKERS

The division of patients in a nursing home into categories is an organizational arrangement intended to foster economic efficiencies (Vladeck, 1980: 135). Categorization permits administrators

to assign staff and target other resources in accordance with the diverse needs of the resident population. Within a category, services tend to be geared to the average level of disability (Penchansky and Taubenhaus, 1965: 593-595). The types of assistance required by only a few residents may be too rare to warrant the institution of routine care procedures; rather, such services would be provided in response to individual requests, to the extent that staff time permits. However, categorization has the potential for increasing a home's ability to respond effectively to rare needs, since, if the groupings are made homogeneous in terms of disability level, many patient requests would no longer reflect the requirements of a minority and could justify the introduction of routine procedures.[7]

Following this reasoning, the greater the number of categories, the more homogeneous the residents in a group, and the more finely services could be tailored to their needs. Both economic efficiency and responsiveness would be served. However, elaborate categorization has costs. With respect to efficiency, the empty beds in one resident category could not be filled from an overflow of patients appropriate to another division. With regard to patient welfare, because an individual's disability level is not a stable attribute, the use of multiple categories would require considerable movement of patients, if relatively homogeneous residence groups are to be maintained. Even when such shifts occur within a single institution, they can be disruptive of the precarious social life of elderly persons. As a consequence, we would recommend against instituting more categories than the two broad ones in current use.

A different approach to categorization emphasizes the specialization of workers. The economic benefits of a division of labor are, of course, well understood, and all complex organizations utilize this principle. What is less well appreciated is the use of specialization as a tactic for administrative control over staff activities. Where workers have multiple responsibilities and where many of the tasks are nonroutine, not controlled by schedules, they have considerable discretion in deciding how to allocate their time. Indeed, as we have argued, it is precisely this discretion which creates staff power over residents and permits workers to ignore many requests for service. However, specialization can be used to ensure that each of the various responsibilities

of the staff receives its proper emphasis. In particular, complex chores could be subdivided into component tasks, and each assigned a number of workers that reflects the home's view of its importance. A narrowing of responsibility would reduce worker discretion and enhance the ability of home administrators to hold staff acountable for the performance of specific jobs.

The cost of coordination is the price associated with a division of labor. The advantages of specialization, therefore, are limited to chores which either require multiple skills or which do not have to be performed at a single time with the same patient. Where this is not the case and specialization would create coordination problems, a better alternative would be to devise a complex reward structure which is sensitive to the performance of each component task or a reward strucutre which incorporates the evaluations of residents. (In supplying ratings, residents would be implicitly aggregating the multiple areas of staff responsibility.) The latter approaches to control over staff were outlined in the preceding section; they are probably the preferred arrangements for providing most of the health and personal care services required by nursing home patients.

Yet, there are tasks which could be separated from the multiple responsibilities of nurses' aides and attendants and which are often neglected in the press of competing work demands. A prominent example concerns staff obligations with respect to physical rehabilitation.[8] The tasks in this area are sufficiently distinct from personal care chores that assigning them to different personnel would not create coordination problems. One advantage of separation is that, as we have indicated, it would give home administrators greater control over the performance of diverse jobs. As a second benefit, it would permit a nursing home to acquaint different categories of workers with different norms and reward them according to standards of performance appropriate to their narrow areas of responsibility. In particular, it may be unreasonable to hold personal care workers accountable for patient improvement, since the bulk of their time is occupied with patient maintenance. The situation would be different, however, for staff whose primary responsibility is to exercise residents and assist in their rehabilitation; workers with this specialization could be trained to expect patient improvement and rewarded on the basis of patient progress.

Implications for Policy

The better nursing homes for the aged are nonprofit institutions, often sponsored by religious associations. The physical plant may be attractive, and the administrators and senior staff are committed to providing a humane environment for the elderly, infirm persons. Nonetheless, these intentions frequently are not translated successfully into practice. Although residents come to the homes to live out their lives with some modicum of pleasure and comfort, not to recover from illness, it is as social settings that nursing homes are especially problematic. The lives of residents are regimented; they are dependent upon staff schedules for assistance with personal needs and they retain little control over how the time in a day will be spent.

In this article our objective was to explore some of the organizational factors that are responsible for the poor quality of life in many nursing homes. We have concentrated on issues which involve the notions of *reward structure* and *categorization* (or specialization) because these considerations have received much attention in the formulation of governmental policy and because we concur that arrangements on these matters carry great importance for patient welfare. Governmental interest in organizational issues stems from a concern about controlling the escalating costs of nursing home care and from a desire to influence the allocation of resources among patients with different levels of need. Yet, the consequences of the arrangements that have been adopted are detrimental to the quality of life of elderly persons.

It is our contention that every reward structure has built-in inducements for behaviors that are dysfunctional from the point of view of policy makers. These distortions of intent are a natural consequence of an attempt to guide behavior in a complex institution through the use of a few simple rules to determine a home's income. Analogous difficulties within a nursing home, concerning staff performance, can also be understood in terms of inadequacies of a reward structure. Here the problem was diagnosed as a situation in which personal care workers have multiple responsibilities while residents lack the power to influence staff use of time. In some institutions, supervision and the

reward structure can be augmented with the control effects of socialization. However, a dependence upon value internalization requires workers who are empathetic to the needs of the elderly and, because of location, many nursing homes cannot recruit low-skilled personnel who are responsive to value training.

In line with this analysis, our inclination is *not* to conclude by proposing yet another reimbursement scheme for homes or reward structure for staff. Improvements certainly can be devised (e.g., Kane and Kane, 1978; Sand and Berni, 1974) and we have suggested some innovations in this article. However, our principal conclusion is that, because of the complexity of patient needs, no single control structure is likely to be adequate for ensuring patient welfare. Patients will fare best where many concerned groups are active, each monitoring the operation of a home from the vantage of its own perspective. In the private sector, reward structures effectively control staff performance because changes in patronization provide feedback to a firm, and the parameters of the reward structure can be adjusted accordingly. A comparable feedback mechanism does not exist in nursing homes, but we suggest that this same function could be served by the presence of multiple evaluation structures, each focusing upon patient welfare from its own special viewpoint. In this situation, the insensitiveness of existing control arrangements would be moderated by the reactions of particular constituencies to behaviors that fall within their domains. State governments can play a supportive role in this endeavor, in addition to their licensing and inspection programs, by legitimating the right of concerned groups (of relatives, elderly persons in the community, and others) to gain access to nursing homes as observers.

From a different perspective, a central problem faced by nursing homes concerns the delivery of nonroutine services in a manner that is responsive to patient wishes. Nursing homes achieve economies by routinizing the provision of care, and there consequently is a tendency to force many patient needs into a framework of routine, even when they cannot be adequately accommodated in this way. One strategy for increasing responsiveness involves the categorization of patients or staff. This sort of solution promises to restructure the distribution of patient needs, or reorganize the delivery of services, in ways that heighten

staff responsiveness as well as promote efficiency. The advantages and limitations of these approaches were discussed in the article. A second strategy would focus solely on arrangements to enhance responsiveness, in the view that pressures for efficiency are already powerful and one must bolster a home's commitment to meeting the idiosyncratic needs of patients. Attempts to increase patient influence in the reward structure for staff, and strategies for bringing the operation of nursing homes under the observation of concerned groups, represent solutions of the latter sort; they are not intended to contribute to efficiency. A still different approach, suggested by Litwak (1977), would make use of the special suitability of primary group members for meeting the nonroutine needs of residents. However, because primary group members often are not available, we have concentrated in this article on bureaucratic arrangements.

NOTES

1. Norms are usually set for classes of nursing homes (e.g., in New York State, size, location, and quality affect the reimbursement rate), and homes within a category can bill no more than a certain percentage of their group average (e.g., 110%). Such payment determination tends to be insensitive to a facility's actual expenses and forces all homes in a category to have similar reimbursement rates.

2. Hospitals and doctors face an analogous dilemma in deciding when to discontinue the use of expensive life-sustaining equipment by a comatose patient. The situation we describe is somewhat different in that there is no question of brain death at the time support is curtailed. Further, hospital patients have legal rights in a decision to withdraw support whereas the interests of nursing home patients are not represented in resource allocation decisions.

Yet, as N. Rango has reminded us, the case of a patient who requires intensive nursing services has little prospect for recovery of function raises terrible ethical issues. It is a problem that we will eventually have to confront, because societal resources are limted and because the percentage of the U.S. population in the older-than-75 age group will increase substantially in the present decade.

3. In extreme cases of staff alienation, patients may be treated virtually as objects. They will be dressed without being asked which clothes they wish to wear; they will be taken to social activities or for personal services (e.g., hairdressing) without being consulted or informed about the destination. Thus, not only is control lost over the rudiments of their lives but also residents may be cut off from information concerning what is happening to them.

4. The evaluations would have to be collected in a manner that maintains patient confidentiality in order to protect residents from pressure or retaliation by personal care workers.

5. Even though nursing homes are properly sensitive to the disruptive effects of tipping and bribery, administrators encourage a version of this practice. When beds are

scarce a home may require a "contribution" from a prospective patient's family to secure admission.

6. The precise category is "Personal care and domiciliary care facilities."

7. One example relates to recreational activities. The better nursing homes have game rooms and schedule concerts and other events each week in a central auditorium. A question, however, concerns how residents get to the activities. In the homes we observed, a crucial consideration was the ability of a patient to propel his wheelchair along corridors. Where patients had this faculty, they were in a position to enjoy the recreational program of the home. However, patients who lacked the necessary arm strength were dependent upon the staff to transport them, and this was rarely done. Because most of the residents were bedridden, the routines instituted by the home were geared to patients in this condition, and the staff sought to simplify their own chores by treating all incapacitated residents as requiring, essentially, the same service routine.

8. While many nursing homes have rehabilitation professionals on staff who work with residents a few times each week, it is also necessary that the residents exercise daily to build muscle strength. Assistance with these simple exercises is supposed to be given by personal care workers. However, the assistance often is not provided. Unlike feeding and washing patients, or changing linen, there are few overt signs that can indicate to a supervisor whether a patient has been properly exercised.

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