Political Perspectives on Uncertified Home Care Agencies

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This article examines the political agendas of public sector and organized private sector interests concerned with policies affecting uncertified home care agencies in three metropolitan areas. Using a telephone survey, the study found substantial differences across these groups in both the frequency with which they work on given issues and in some key attitudes. Overall, respondents were most likely to work on policies related to home care quality, and had particularly diverse—and at times conflicting—concerns in this area. Policymakers need to actively solicit the diverse attitudes of key interest groups towards controversial issues in order to understand less dominant perspectives, keep in mind the interconnection of policy issues, and arrive at politically viable solutions to home care policy problems.

INTRODUCTION

Home care (the provision of a broad range of health and social services to individuals and their families in the home) is a booming component of health care (Neu and Harrison, 1987; U.S. General Accounting Office, 1988; Van Gelder and Bernstein, 1986). It is, therefore, increasingly important to examine the policies and policy debates which shape in-home services. In particular, little is known about the large segment of home care agencies which is not certified by the Federal Government. This article examines the political agendas of public sector and organized private sector interests concerned with uncertified home care policy in three metropolitan areas: San Francisco, Houston, and Philadelphia. We discuss the relative prominence of quality, cost, and access-related policies on the political agendas of these groups and agencies and describe the nature of their policy concerns. Finally, the article examines two issues in light of this research: (1) the characteristics of home care politics, and (2) the potential contribution of the different perspectives of government, home care providers, consumers, and others for policy analysis.

Significance

Home care services are defined in this article as assistance provided in the home which enables a person with an illness or disability to remain in his/her residence. These services include what are often referred to as home health services (nursing, administration of medications by a home health aide, etc.) and home care support (chores, assistance with dressing, etc.). Home care is the fastest-growing component of personal health care expenditures (Letsch et al., 1992). According to one estimate, the home care market grew 10 percent annually between 1986 and 1991 (National Association for Health Care, 1993). Home care was a $12 billion industry in 1991 (Letsch et al., 1992) and is expected to reach $40 billion in 2018 (Wiener and Illston, 1994). A number of factors have contributed to the increased

demand for this type of assistance. These include the aging of the population, the implementation of policies shortening hospital stays, and the advent of technologies which make such care feasible for an increasing variety of consumers (Estes et al., 1992; U.S. House of Representatives, 1987; Stark, 1987; U.S. Department of Commerce, 1990). The enormous growth of the home care industry, along with spiraling long-term care costs, has focused attention on cost, access, and quality issues for in-home services (Estes et al., 1992).

The variety of home care providers can be roughly grouped into three categories: agencies certified by the Federal Government, uncertified agencies, and independent providers, i.e., individuals providing in-home services.[1] Most attention has been focused on the services provided by those agencies which are certified and paid for by the Medicare or Medicaid programs. Very little is known about uncertified providers of home care services to the elderly and disabled (Harrington and Grant, 1990).

Yet, uncertified agencies—the focus of this article—are both conceptually and numerically a major part of the home care market. Recent studies have found that approximately one-half of all home care agencies are uncertified (U.S. Department of Commerce, 1990; National Association for Home Care, 1993; Estes et al., 1993). These agencies offer a broad range of services. Only those home care agencies which provide nursing services and at least one other therapeutic service can be federally certified. Furthermore, agencies close to

meeting certification standards may choose not to certify.

Current research shows that the four most common barriers to certification in the eyes of uncertified agencies are the paperwork, costs, and bureaucracy associated with the process, followed by a perception that Medicare and Medicaid reimbursement levels are inadequate.[2] Home care agencies need not certify to survive, as they have alternative funding sources available to them, including Government programs and out-of-pocket payments. Thus, uncertified agencies include all those providing only nursing or one therapeutic service, agencies offering only nonmedical services, and agencies potentially eligible for certification which choose not to participate in that process.

The Role of Public Policy in Shaping Home Care

Uncertified agencies, like the certified, are affected by government policy in significant ways. Certification policy itself shapes the uncertified sector by determining which types of agencies can receive direct reimbursement from Medicare and the Medicaid home health benefit and which cannot. This is enormously important, as Medicare alone accounts for 45 percent of home health expenditures (Letsch et al., 1992). Certification policy also creates incentives and barriers which condition an agency's decision as to whether to become certified, thereby shaping the agency pool. Furthermore, home care agencies may be directly regulated by State government through their licensure rules.

[1] This study focused on uncertified agencies only, because inclusion of independent providers, the authors believed, would make the study too broad. As will be seen, however, it is impossible to examine the politics surrounding uncertified agencies without attention to the other sectors of the home care market.

[2] Unpublished results of the study "Uncertified/Unlicensed Home Care: Structure and Performance," conducted by C.L. Estes, C. Harrington, and A.E. Benjamin, principal and co-principal investigators, at the Institute for Health and Aging, UCSF, ongoing.

In California, Texas, and Pennsylvania— the three States included in this study— the standards prescribed by licensure are very close to certification regulations, although the type of agencies eligible differs. Half of the uncertified agencies in the study States are licensed (Estes et al., 1993). Furthermore, local government offices frequently contract for services with providers; the conditions they establish for such contracts are a de facto form of regulation for the participants.

Government funding policies also shape home care. Medicaid is a growing source of funding for all home care. In addition to a mandatory home health benefit, Medicaid provides two optional sources of funding for home care: the Personal Care Option, and the 2176 Home and Community-Based Services waiver program (Miller, 1992). States may reimburse uncertified agencies and independent providers, as well as certified agencies, through these programs. Two additional Federal funding sources which reimburse for uncertified care are administered by the States: the Older Americans Act and the Social Service Block Grants program. All of these funding sources—as well as State and local funds—shape home care demand, the type of services provided, home care costs and access for those unable to pay out of pocket. Finally, home care agencies are affected by a number of government policies with broader targets: workers' compensation, minimum wage laws, etc.

Home Care Policy Questions: Cost, Quality, and Access

Health policy concerns have been generally classified into three major categories: cost of care, quality of care, and access to care. That same classification scheme has been utilized in this analysis for characterizing respondents' political agendas. These agendas are pertinent to central debates about home care policy in general and may have a significant impact on future home care policies.

Historically, home care has been analyzed primarily in terms of its potential contribution to cost containment in the hospital sector, rather than as a significant form of health care in its own right (Benjamin, 1993). A variant of this approach has been the view that home care is justified as a cost-effective alternative to nursing homes, although studies of home care have not demonstrated that it is a cost-effective alternative to institutionalization (Weissert, 1991). However, some argue that cost-effectiveness is not the most important criterion by which to assess proper use of home care. A more appropriate concern, it is suggested, is assuring that people receive the long-term care they need (Applebaum and Flint, 1993). At a time when inflationary health care expenditures have motivated policy efforts to contain costs throughout the health care system, cost containment within the home care arena and the use of home care to control other sectoral or overall costs is a key policy concern. Uncertified care is promoted by some in the belief that it is a particularly low-cost form of long-term care because providers do not have to meet regulatory standards for staffing, bookkeeping, etc. (Harrington and Grant, 1990).

For home care—as for other types of health care—the issue of quality is also receiving a great deal of scholarly attention. This issue is particularly important for the study of uncertified home care, since

the primary justification for certification is quality control. The task of improving the quality of health care services, however, is not cut and dried. It involves difficulties which can be particularly acute for in-home services, although they are by no means confined to that sector of health care. These problems include the difficulty of measuring outcomes (particularly for very ill populations), varying and sometimes conflicting components of quality, problems of enforcement, lack of information about the efficacy of quality measures, conflicts over the control of care, the adverse impact of regulation on cost and flexibility, the variety of services provided, and the dependence which both payers and consumers have on the caregivers they need to monitor (Weitzman, 1990; Grant and Harrington, 1989; Applebaum and Philips, 1990; DeLissovoy and Feustle, 1991; Sabatino, 1989).

Finally, access is an ongoing concern for home care. Barriers to health care access can result from financial causes (such as high costs and insufficient payment sources) or from non-financial causes (such as lack of appropriate services, language barriers, or poor management of public or non-profit programs). Researchers have suggested that insufficient access to appropriate in-home services is a major problem and has contributed to unnecessary institutionalization (Estes and Swan, 1994, 1993; Rowland and Lyons, 1991).

The Politics of Home Care Policy

Studies of health care politics document the crucial influence of interest group activity on policy debates and policy outcomes such as those just described (Alford, 1975; Estes, 1979; Litman and Robins, 1991). Given the hidden nature of uncertified home care agencies, we know little about the politics which shape their regulation and funding. A case study of California interest group attitudes towards home care regulation, however, suggested differing interest group positions on this topic (Harrington and Grant, 1990). This article helps us to understand uncertified home care politics by analyzing the political agendas of government, providers, consumers, and others on a broad range of issues.

The organizations included in the study are from here on referred to as "stakeholders" to convey the fact that they are highly affected by home care policies. The stakes held by the groups can be material, such as the economic interests of providers or the physical well-being of consumers. They can also be symbolic, such as the sense of purpose of an agency funding care. Frequently, they are both, as when a government agency's desire to maintain its funds stems from a belief in the agency's mission and a material stake in the jobs of the employees.

The stakes, or perceived stakes, of different groups are at the heart of politics, which has been described as the question of "who gets what, where, when, and how" (Lasswell, 1958). Understanding stakeholder political agendas answers four questions about uncertified home care politics:

- Which players are involved in trying to influence policy and which are not?
- Which issues have made it onto the agendas of organized and institutional interests, the first step in an issue or policy alternative having any chance of policy influence (Cobb and Elder, 1983)?
- What are specific stakeholders' policy positions and how do they perceive their political interests?
- What is the configuration of the political arena, i.e., where are there points of agreement and where are there points of potential conflict?

Based on analyses of health care politics, this study was undertaken with the supposition that the perceived interests and political agendas of the major categories of political players would be heterogeneous and sometimes conflicting. As the analysis proceeded, we were struck by the particular relevance to Alford's (1975) work on health politics. Providers, Alford argues, are "professional monopolizers," attempting to maintain their hold on the health care market. Government agencies are "corporate rationalizers," attempting to control and systematize health care services. The result of this configuration is an attempt to control or rationalize an inequitable and flawed system. Consumer populations attempt to challenge this status quo. The study described here was designed to examine the political interests and activities of key groups, and cannot tell us who has power in the political process or what its outcome will be. However, we can compare the configuration of interests described by Alford with that found in this study, and we can hypothesize about its relationship to home care policy decisions.

The study also allows for testing and generation of hypotheses about the origins of stakeholders' policy agendas. This study assumes, and examines its assumption, that political positions are fundamentally linked to economic interests. One key hypothesis based on this theoretical framework is that provider associations will act in accord with theories of professional association rooted in economic self-interest (Feldstein, 1991). These arguments hold that professional associations will promote an expansion of the types of agencies or individuals requiring licensure (thereby controlling supply and increasing competitors' costs) and a loosening of the actual requirements for those who are licensed (thereby decreasing their own costs).

However, while economic interests go a long way toward explaining political positions, they do not account for all variation. Political action around a policy issue results not from "objective," but perceived policy interests, and requires that a particular set of concerns be given priority. Furthermore, symbolic concerns may motivate some behavior. This article hypothesizes about the role of two factors in particular—public policy itself and the presence and strength of specific organized interests—in shaping perceived interests and perceived policy solutions in the home care arena.

Stone (1988) points out that "policy analysis is political argument and vice versa." The fact that policy positions correspond to interests does not make them wrong or tainted. However, policymakers rely heavily on organized interests for information, and understanding the stakes of a policy debate can help decisionmakers to look beyond the information which is presented to them. Furthermore, as policy is made, certain ideas and certain voices come to predominate. Looking at stakeholder agendas reveals to us other, less prominent perspectives and approaches which policy analysts should consider.

In addition, policymaking in a pluralist, decentralized system like that of the United States often produces fragmented responses to political pressure and policy problems. Examination of the original positions of stakeholders highlights the interconnections between policy issues and, therefore, the stakes of policy. Finally, politics is not just a factor in policy outcomes, but a result of policy itself. Political analysis of home care can help us to understand more fully the consequences of different policy options, including the generation of political activity which can facilitate or hinder home care policy implementation or further policymaking.

METHODS

The data for this article were collected in a survey of "key informants," conducted at the Institute for Health and Aging from April to October of 1993. This survey is part of a larger study of uncertified home care agencies in the Houston, Philadelphia, and San Francisco standard metropolitan statistical areas (SMSAs) that is funded by AHCPR. In addition to the key informant survey, the larger study includes a survey of the universe of uncertified home care agencies in the three locations.[3]

Sample

The key informant sample is a purposive sample, primarily comprised of respondents with stakes in the uncertified home care arena in the three SMSAs. The sampling strategy was maximum variation sampling, i.e., respondents chosen represent the range of organizations and institutions with stakes in the home care policy arena. An original list of respondents and respondent types was created based on studies of certified home health care utilizing key informants (Estes and Swan, 1993; Estes et al., 1993). The sample was expanded through limited snowball sampling, in which each respondent is asked to recommend others, and opportunistic sampling,

in which interview content suggests new respondent types. Selection of additional respondents was based on the criterion of achieving maximum variation among respondents with knowledge of policies affecting uncertified home care. We sought out the respondent from each institution or organization who was identified as being the most informed on issues relating to the uncertified home care market and public policy. Out of 293 contacts, only 4 percent were selected for interviewing but could not be reached or refused the interview.

The study sample consists of the following groups of stakeholders:

• Government: Government agencies and legislative committees connected to the funding and regulation of home care. These have been further divided given their different functions:

—Local government agencies: The front-line agencies administering public funding of home care. These include Area Agencies on Aging and County Departments of Social or Human Services. Within the boundaries of State and Federal regulations, local government makes service delivery and funding decisions.

—State agencies: The State agencies which fund and/or administer public reimbursement of home care. These are located within Departments of Aging, Health, Mental Health Human Services, and Public Welfare. These agencies serve as conduits for Federal funds and, within Federal guidelines, make some decisions about the structure of funding streams and program administration, services provided, eligibility, and provider type. State programs may also administer State funds for home care. The sample is not restricted to programs which will use uncertified agencies as providers, but is predominantly made up of such respondents.

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[3]The total sample size for the larger study of key informants is 105. This includes umbrella organizations (i.e., non-profit agencies which fund home care, local and State government agencies which fund and administer home care programs), State offices which license home care agencies, legislative aides to relevant State assembly or senate committees, home care and related trade associations, consumer groups and consumer advocacy groups, State insurance departments, and other key actors relevant to specific communities. In addition, a number of representatives of national consumer groups and trade associations were interviewed, allowing for comparison of their responses with those of their State and local counterparts. Interviewees also included national organizations which accredit home care and health care researchers.

—State Licensing Departments: The agencies responsible for the States' licensure of home health agencies. In the study States, these are all located within the State Departments of Health.

—State Insurance Departments: The agencies regulating private health insurance, including long-term care insurance.

—Legislative Aides: Staff members from the State legislative committees most involved with the legislation affecting uncertified home care agencies, including Health, Welfare, and/or Human Services committees.

• Provider Trade Associations: Associations representing providers of home care, organized primarily at the State level, but at times locally. In addition to associations representing general home care agencies, the sample includes associations of durable medical equipment providers and representatives of hospital associations responsible for their home care holdings.

• Consumer and Consumer Advocacy Groups: Organizations which are active in the areas of health care for the elderly and/or the disabled, the primary consumers of home care, or which specifically work on long-term care. They may be organizations which are run by the consumers themselves or advocacy groups. Some are State or local branches of national organizations, while others are organized at the State or local level; some of the latter, however, are affiliated with larger movements.

• Umbrella organizations: Religious charities and other philanthropic organizations which directly fund uncertified home care.

• Related trade associations: Associations representing health care providers from service sectors related to home care, including nurses and adult day health care.

• Union: Only one union in the three study SMSAs is actively representing home health aides and other home care support workers.

Almost all purposive samples miss some sources of variation. In this case, analysis of those contacts who met the study criteria but were not interviewed reveals three important characteristics of the sample. First, while other consumer groups were well represented, disease-specific groups were less so. Second, potentially important is the exclusion of local government mental health/mental retardation agencies and related consumer groups. These informants were excluded because they are participating in a companion study. (State mental health agencies were interviewed in two of the three States; in the third, we were unable to attain an interview.) Third, we were unable to enlist the cooperation of insurance company trade associations. The implications of these sample characteristics are discussed at the end of the article.

A core set of questions was asked of the majority of respondents. These cover the areas of social, economic/fiscal, and policy/regulatory conditions affecting uncertified home care; unmet needs; perceptions of different agency types; and political agendas and experience. In addition, subsets of questions were developed for different respondent types to tap their particular areas of expertise and experience. Thus, the total number of respondents varies according to the questions asked. The data reported for this article come from 75 State and local respondents. The sample is described in Table 1.

The sample is uneven for the three locations because of State differences in the structure of policy and in leads provided by other respondents (which may reflect

Respondent Type	SMSA			
	Total	San Francisco	Philadelphia	Houston
Total	34	34	23	18
Public Sector Subtotal	17	17	13	9
Local Government Agencies	8	8	7	2
State Agencies Funding/Administering Programs	5	5	3	4
Licensing Departments	1	1	1	1
Insurance Departments	1	1	1	1
Legislative Aides	2	2	1	1
Private Sector Subtotal	17	17	10	9
Umbrella Organizations	4	4	4	3
Trade Associations	4	4	4	3
Related Trade Associations	1	1	1	0
Unions	1	1	0	0
Elderly Consumer Advocacy Groups	2	2	0	2
Disabilities Consumer Advocacy Groups	3	3	1	1
General Consumer Advocacy Groups	2	2	0	0

NOTE: SMSA is standard metropolitan statistical area.

SOURCE: Institute for Health and Aging, University of California, San Francisco, 1994.

different levels of awareness about uncertified home care). For example, only two local government agencies were interviewed in Houston, because the relevant local agencies there are only administrative arms of State agencies; staff therefore consistently referred us back to the State agencies for discussion of policy.

DATA

The data for this article are responses to the following questions:

- "What policies related to uncertified home care has your organization been most interested in trying to influence in recent years?"
- "What are the outcomes you hoped to see for these policies and why?"
- "What policies are you currently hoping to influence relative to uncertified home care?"[4]

Interviewees generally responded to the question with both their recent and current political agendas, so all responses for an individual were grouped to create the single variable of current and recent political agenda, relating to uncertified home care.

Up to three policies were coded for each respondent; a negligible number of respondents mentioned more than three policies.[5]

The first level of analysis determines the frequency with which respondents reported attempting to influence quality, cost, and access-related policies or no policies at all. This categorization allows for comparison of different attitudes towards, approaches to, and understandings of, the same policy goal or issue. The category of quality-related policies includes responses relating to agency regulation; worker training, regulation, or incentives; and the locus of control over care, e.g., consumer control or case management. Responses relating to worker incentives (i.e., benefits or wages) are included in this category, as well as in the

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[4]Respondents were told at the beginning of the survey that the focus of the study was uncertified home care agencies. However, we allowed respondents to address the gamut of uncertified home care issues through our wording of this question, because of the interaction between the independent provider and agency sectors.
[5]Three respondents had also been included in a small survey designed to help shape our study instrument. These respondents were asked their recent and current agendas during this small survey; the interviewer read the responses back to them at the time of the actual study and gave them the opportunity to confirm or revise their responses.

cost category, when quality improvement was a clear goal. Policies aimed at affecting access to care include funding policies and policies affecting administrative obstacles to appropriate care; they also include work on health care reform to benefit home care. Cost-related policies include those related to the overall cost of services, such as cost-containment efforts or reimbursement levels, as well as policies relating to the structure of agency costs, such as policies affecting worker wages and benefits. This frequency distribution was examined for the total sample, as well as by SMSA and for public and private actors.

The policy categories were then further disaggregated inductively. It was found that respondents working on the issue of costs and cost structure had different goals, making this the primary basis of further disaggregation. Weinstein and Sherman's (1980) schema for characterizing public policy was helpful in analyzing the quality and access categories. This typology was created to broaden analysts' thinking about the range of strategies available for achieving a single goal, and, thus, corresponds well to the goals of this article. Two inter-related dimensions of the typology proved particularly useful: the policy pressure point and the lever of policy. The policy pressure point refers to where in the production process policies are supposed to exert pressure towards their final end, such as at specific inputs to production (labor, capital, etc.), the process of production, the marketing of the product, etc. Examples of pressure points in home care are labor inputs (i.e., workers) or agency procedures. The policy lever is the instrument used to create change at the pressure point, for example, an order/mandate or an incentive (increased pay).

Analysis of the basic distribution of responses was combined with a qualitative

analysis of the same data to better understand the positions of stakeholders. This qualitative analysis utilized answers to other questions from the survey when necessary in order to clarify respondents' political positions.

Results

The Overall Political Agenda

Almost one-third of the total sample responded that the questions did not apply to them or that they were not working on any policies relating to uncertified home care (Table 2). Relative to their representation in the sample, two groups appear in this category particularly frequently: umbrella organizations and elderly consumer advocacy groups. Six percent of the total sample responded "Don't Know," or "Refuse to State." All of the State insurance departments were in this or the "None/Does Not Apply" category.

The frequency distributions for respondents' political agendas are displayed in Table 3. Of the 75 respondents, 48 provided responses. Of those 48, 83 percent reported working on policies categorized as quality-related. In contrast, attempts to influence access-related policies were reported by 42 percent of these respondents, and attempts to influence cost-related policies were reported by 27 percent. As Table 3 shows, the pattern is essentially the same for both private and public sector respondents. A notable difference, however, is that more than twice as many private sector respondents as public sector respondents are working on access-related policies. The question of which respondents are concerned with access is explored further in the access section of this article. Table 4 shows the breakdown of responses by SMSA. Again, the pattern is similar, with

Table 2
State and Local Respondents Reporting No Political Activity Around Uncertified Home Care or Unable to Answer: Response, by Respondent Type

Respondent Type	Total	None/Does Not Apply	Don't Know	Refuse to State
		Response		
Total	27/75	22/75	4/75	1/75
Public Sector Subtotal	14/39	10/39	3/39	1/39
Local Government Agencies	7/17	5/17	2/17	0/17
State Agencies Funding/Administering Programs	4/12	4/12	0/12	0/12
Licensing Departments	0/3	0/3	0/3	0/3
Insurance Departments	3/3	1/3	1/3	1/3
Legislative Aides	0/4	0/4	0/4	0/4
Private Sector Subtotal	13/36	12/36	1/36	0/36
Umbrella Organizations	8/11	8/11	0/11	0/11
Trade Associations	2/11	1/11	1/11	0/11
Related Trade Associations	0/2	0/2	0/2	0/2
Unions	0/1	0/1	0/1	0/1
Elderly Consumer Advocacy Groups	3/3	3/4	0/4	0/4
All Other Consumer Advocacy Groups	0/7	0/6	0/6	0/6

SOURCE: Institute for Health and Aging, University of California, San Francisco, 1994.

Table 3
State and Local Respondents' Political Agendas: Policy Frequency, by Public and Private Sectors[1]

Policy Type	Total ($n = 48$)	Public Sector ($n = 25$)	Private Sector ($n = 23$)
		Respondent Types	
		Percent	
Quality-Related Policies	83	78	88
Access-Related Policies	42	61	24
Cost-Related Policies	27	30	24

[1]Responses of "None," "Does Not Apply," "Don't Know," and "Refuse to State" have been removed from the sample. Percentages do not add up to 100 vertically because respondents were allowed more than one response.

SOURCE: Institute for Health and Aging, University of California, San Francisco, 1994.

quality-related policies reported most frequently, and access-related policies reported more often than, or as frequently as, cost-related policies. No differences of proportion seem substantial here, given the sample size.

Quality-Related Concerns

Some major approaches to quality, varying according to pressure point, emerge from the data. Each policy category is also described according to the policy lever or levers involved. Within the one category for which multiple levers are involved, the analysis examines the subcategories of respondents resulting from further disaggregation by policy lever. The main policy categories include:

- Policies related to regulation of agencies (i.e., the pressure point is the agency's overall procedures and structures, and the lever is regulation).
- Policies related to training or incentive structures (the policy levers) of individual workers (the pressure point).
- Policies relating to decisionmaking and control in the production process of home care services.
- Policies related to quality, but which were unspecified.

The overall distribution of respondent types concerned with quality is displayed in Table 5 and the distribution within the four categories of quality responses in Table 6. The predominant respondents

Table 4

State and Local Respondents' Political Agendas: Policy Frequency, by Standard Metropolitan Statistical Area[1]

Policy Type	Total (n = 48)	Philadelphia (n = 14)	Houston (n = 10)	San Francisco (n = 24)
	Respondent Types			
	Percent			
Quality-Related Policies	83	88	71	90
Access-Related Policies	42	42	36	50
Cost-Related Policies	27	33	29	10

[1]Responses of "None," "Does Not Apply," "Don't Know," and "Refuse to State" have been removed from the sample. Percentages do not add up to 100 vertically because respondents were allowed more than one response.

SOURCE: Institute for Health and Aging, University of California, San Francisco, 1994.

who focused on regulation of agencies are home care trade associations and government officials. The primary concern of the trade associations is with expanding regulation to include non-medical home care agencies, either via certification, licensure, contract regulations, or some unspecified regulatory process.

The associations argue that regulation improves quality of care and the reputation of their industry. Home care trade associations have other concerns as well, most notably flexibility in the actual requirements of regulation. Three trade association respondents reported working to create or maintain different regulatory standards for different types of home care or to relax some existing regulatory requirements.

A number of the public sector respondents echoed these themes. Many have worked or are working to expand regulation to cover non-medical agencies. Again, like trade associations, a number of government agencies are working on maintaining separate tiers of regulation for different agency types or on making regulatory requirements less stringent or more flexible. Others are concerned with the standardization of regulations across levels of government or between government and private accrediting bodies.

The second category of quality-related responses focuses on the individual

caregiver as the pressure point. Training was by far the most common policy lever reflected in these responses, and the predominant aim was to see an increase in training levels. Respondents discussed training for individual workers without specifying whether the training would be voluntary or mandatory, so responses of this type may actually have assumed that increased training would be accomplished through worker certification or licensure (still the worker as pressure point) or through agency regulation. However, there was a distinct difference in the composition of respondents who focused on training of home care workers and those who focused on agency regulation. Responses conceptualizing the individual worker as the pressure point were provided primarily by local government offices. This reinforced our sense that training-related responses reflected a very different focus from responses about agency regulation and should, therefore, be grouped in the caregiver as pressure point category.

A small number of additional respondents spoke to the worker as the point of policy intervention. Two disabilities consumer groups, a union representative, and a non-home care health service trade association spoke to the need to increase workers' wages and benefits. One intended purpose of this step is to improve the quality of work.

Table 5

State and Local Respondents' Political Agendas: Policy Frequency, by Respondent Type[1]

Respondent Type	Policy Type		
	Quality	Access	Cost
Total	40/48	20/48	13/48
Public Sector Subtotal	22/25	6/25	6/25
Local Government Agencies	9/10	1/10	2/10
State Agencies Funding/Administering Programs	7/8	2/8	1/8
Licensing Departments	3/3	0/3	0/3
Insurance Departments	0/0	0/0	0/0
Legislative Aides	3/4	3/4	3/4
Private Sector Subtotal	18/23	14/23	7/23
Umbrella Organizations	0/3	3/3	0/3
Trade Associations	8/9	3/9	3/9
Related Trade Associations	2/2	0/2	1/2
Unions	1/1	0/1	1/1
Elderly Consumer Advocacy Groups	0/1	1/1	0/1
Disabilities Consumer Advocacy Groups	5/5	5/5	2/5
General Consumer Advocacy Groups	2/2	2/2	0/2

[1]Responses of "None," "Does Not Apply," "Don't Know," and "Refuse to Answer" have been removed from the sample.

SOURCE: Institute for Health and Aging, University of California, San Francisco, 1994.

Table 6

State and Local Respondents' Quality-Related Activities: Proportion of Respondents Reporting Working on Specified Policy Type, by Respondent Type[1]

Respondent Type	Policy Type			
	Agency Regulation	Individual Workers	Locus of Control	Miscellaneous
Total	22/48	14/48	11/48	4/48
Public Sector Subtotal	15/25	8/25	3/25	2/25
Local Government Agencies	3/10	7/10	0/10	0/10
State Agencies Funding/Administering Programs	7/8	1/8	3/8	0/8
Licensing Departments	3/3	0/3	0/3	1/3
Insurance Departments	0/0	0/0	0/0	0/0
Legislative Aides	2/4	0/4	0/4	1/4
Private Sector Subtotal	7/23	6/23	8/23	2/23
Umbrella Organizations	0/3	0/3	0/3	0/3
Trade Associations	5/9	2/9	1/9	1/9
Related Trade Associations	1/2	1/2	1/2	0/2
Unions	0/1	1/1	0/1	0/1
Elderly Consumer Advocacy Groups	0/1	0/1	0/1	0/1
Disabilities Consumer Advocacy Groups	1/5	2/5	5/5	0/5
General Consumer Advocacy Groups	0/2	0/2	1/2	1/2

[1]Responses of "None," "Does Not Apply," "Don't Know," and "Refuse to State" have been removed from the sample.

SOURCE: Institute for Health and Aging, University of California, San Francisco, 1994.

The final category of responses relates to changing the locus of control over home care, and includes discussions of shifts either to the consumer or to a case manager. The predominant issue in this category is consumer control over home care service decisions and home care workers, raised primarily by disabilities groups, but also by a long-term care advocacy group and a non-home care trade association. Respondents addressed the issue of consumer control both in terms of intangible, but very real, concepts such as "autonomy," "control," and "dignity," and in terms of concrete consequences. Disabilities group respondents described control over their services as a way of making care more appropriate to individual needs, improving

overall quality, assuring bodily safety, and decreasing consumer pain and embarrassment. Respondents mentioned the fact that in-home services for those with disabilities can require that service providers touch their bodies a great deal, and argued that they should have control over who touches them and in what manner.

The responses of disabilities groups also focused on three specific policy issues which condition client control of basic employment issues and consumer-directed care. One issue is the clear designation of consumers as the employers of caregivers. Three groups discussed the need to give consumers the options of employing independent providers, rather than agencies.[6] A second concern is the growing trend towards managed care, whether in the form of health maintenance organizations or case management. One group expressed concern that case management leads to the expenditure of more resources on administration rather than care and protested the designation of somebody other than the client as the ultimate arbiter of care. In contrast, a State agency hoped to include case management in a new package of long-term care services, and one consumer advocacy group favored some independent case management when needed.

Disabilities groups cited government regulation, including certification and licensure, as a third obstacle to consumer control, taking authority over the training of workers out of the hands of consumers and failing to provide the quality assurance they desire. Interviewees argued that the personal care services which constitute much of in-home care for persons with disabilities are not medical, and do not require regulation. A final variation on the theme of consumer control was sounded by a consortium of providers, who felt that a consortium like theirs could be held accountable to consumers.The three SMSAs in the sample show essentially the same pattern of policy positions among respondent types. Those small differences which appear may be artifacts of a small sampling frame. However, it is interesting to note that all four respondents who discussed the need to raise workers' wages were from California. In addition, California is the only State where the issue of consumer control was raised by respondents other than disabilities groups; in California, it was raised by two other respondents.

Access-Related Concerns

Access-related responses were recorded for 42 percent of the 48 respondents participating in uncertified home care politics. There were no obvious differences among the three SMSAs which seemed substantial, given the small sample size. As noted, there is a substantial difference in the frequency with which public and private sector respondents are working on access issues, with private sector respondents two and one-half times more likely to do so. Among the private sector respondents working on access issues, more than one-half were consumer or consumer advocacy groups.

All of the access-related responses addressed the same pressure point: the home care market's demand side. Two different policy levers emerged: government regulation of insurance funding and direct government funding of care. The second category (direct government funding) further subdivided into what was to be changed relative to the policy lever in order

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[6] In Texas, a respondent from an activist disabilities group felt it possible to create such consumer control within the context of agency-provided care. However, other disabilities groups clearly see independent providers as the only real means of ensuring consumer control; they argued that agencies assume control over assignment of aides, over training, and even over daily decisionmaking in the home.

Table 7

State and Local Respondents' Access-Related Activities: Proportion of Respondents Reporting Working on Specified Policy Type, by Respondent Type[1]

Respondent Type	Policy Type				
	Insurance Regulation	Overall Public Funding/ Service Levels	Public Home Support Funding	Programmatic/ Administrative Change (Public Funds)	Miscellaneous
Total	1/48	7/48	7/48	3/48	6/48
Public Sector Subtotal	0/25	2/25	3/25	0/25	2/25
Local Government Agencies	0/10	0/10	1/10	0/10	0/10
State Agencies Funding/ Administering Programs	0/8	1/8	1/8	0/8	0/8
Licensing Departments	0/3	0/3	0/3	0/3	0/3
Insurance Departments	0/0	0/0	0/0	0/0	0/0
Legislative Aides	0/4	1/4	1/4	0/4	2/4
Private Sector Subtotal	1/23	5/23	4/23	3/23	4/23
Umbrella Organizations	0/3	0/3	1/3	1/3	1/3
Trade Associations	1/9	1/9	1/9	0/9	2/9
Related Trade Associations	0/2	0/2	0/2	0/2	0/2
Unions	0/1	0/1	0/1	0/1	0/1
Elderly Consumer Advocacy Groups	0/1	1/1	0/1	0/1	0/1
Disabilities Consumer Advocacy Groups	0/5	3/5	1/5	2/5	0/5
General Consumer Advocacy Groups	0/2	0/2	1/2	0/2	1/1

[1]Responses of "None," "Does Not Apply," "Don't Know," and "Refuse to State" have been removed from the sample.

SOURCE: Institute for Health and Aging, University of California, San Francisco, 1994.

to improve access: overall expansion (i.e., increased funding), expansion oriented toward one specific piece of the market (chore and support—rather than medical— services), or restructuring of funding programs/administration for greater effectiveness. Six respondents provided information which was grouped in a miscellaneous category, as they reported working on access with no elaboration, or suggested that they had been working on health care reform for the benefit of home care services, with no further detail. The distribution of access-related responses is presented in Table 7.

Only one respondent addressed government regulation of insurance company policies. The rest were concerned with government funding programs. Most of these respondents wished to see funding levels increased, with equal numbers concerned with overall funding and with increased funding specifically of chore and attendant type services. A few respondents saw a major impediment to service access in

the administrative/programmatic structure of public funding for home care. Concerns included fragmentation across geographic locations and client types, as well as a desired expansion of home care type services to non-home, community-based locations.

Cost-Related Concerns

More than one-quarter of the responding sample stated that they were working or recently had been working to influence issues which were coded as cost-related. There were no obvious differences among the three SMSAs which seemed substantial, given the small sample size. Unlike the categories of quality and access, responses in this category differed relative to the respondents' ultimate goals, not just their preferred approaches to their goals. Six categories of responses presented themselves as follows:

- Lowering agency costs.
- Reducing health care costs through use of home care.

Table 8

State and Local Respondents' Cost-Related Activities: Proportion of Respondents Reporting Working on Specified Policy Type, by Respondent Type[1]

Respondent Type	Policy Type					
	Use Home Care To Reduce Overall Costs	Reduce Home Care Costs	Reduce Agency Cost	Increase Worker Remuneration	Increase/ Maintain Agency Remuneration	Balance Other Goals With Cost Control
Total	1/48	3/48	1/48	4/48	2/48	5/48
Public Sector Subtotal	1/25	2/25	1/25	0/25	0/25	4/25
Local Government Agencies	0/10	0/10	1/10	0/10	0/10	1/10
State Agencies Funding/ Administering Programs	0/8	1/8	0/8	0/8	0/8	1/8
Licensing Departments	0/3	0/3	0/3	0/3	0/3	0/3
Insurance Departments	0/0	0/0	0/0	0/0	0/0	0/0
Legislative Aides	1/4	1/4	0/4	0/4	0/4	2/4
Private Sector Subtotal	0/23	1/23	0/23	4/23	2/23	1/23
Umbrella Organizations	0/3	0/3	0/3	0/3	0/3	0/3
Trade Associations	0/9	1/9	0/9	0/9	2/9	1/9
Related Trade Associations	0/2	0/2	0/2	1/2	0/2	0/2
Unions	0/1	0/1	0/1	1/1	0/1	0/1
Elderly Consumer Advocacy Groups	0/1	0/1	0/1	0/1	0/1	0/1
Disabilities Consumer Advocacy Groups	0/5	0/5	0/5	2/5	0/5	0/5
General Consumer Advocacy Groups	0/2	0/2	0/2	0/2	0/2	0/2

[1]Responses of "None," "Does Not Apply," "Don't Know," and "Refuse to State" have been removed from the sample.

SOURCE: Institute for Health and Aging, University of California, San Francisco, 1994.

• Reducing overall home care costs.
• Increasing workers' remuneration.
• Increasing agency remuneration.
• Achieving other goals within a context of cost containment.

The first three response types are cost containment measures or constitute cost restructuring which would facilitate cost containment. The last three suggest either an increase in spending or a change in resource allocation. The distribution of respondents among these six categories is presented in Table 8.

Goals of health care cost containment or goals which facilitate cost containment were expressed primarily by public sector respondents. Four out of six public sector respondents addressing costs described wanting to keep costs down, either by decreasing workers' compensation costs for agencies, reducing overhead or per service costs, or using home care to reduce overall Medicaid costs. Notably, however, all of these respondents also belonged in the category of respondents who wanted to see cost containment addressed within the context of pursuing another goal or goals: quality, access, adequate funding, or local flexibility. One legislative aide, for example, stated that the policies his committee had been working to influence were:

> "Cost, access, quality, and flexibility of patient needs. We are seeking to balance it out so local decisions can be made without tremendous amounts of overhead...We have to face realities of racial differences and language barriers and work for the best quality of care mindful of individual community needs."

The other two public sector respondents seemed to see cost containment as a contextual reality rather than an organizational goal, with one of them stating that his agency was working against the cost-containment model altogether.

The private sector respondents proved to be even less concerned with cost containment than the public sector respondents. Only one private sector respondent out of seven addressing costs described working for a goal of cost containment; like the public sector informants, the respondent simultaneously described wanting to balance cost effectiveness with the goal of quality. The other six private sector respondents were all working on goals relating to increasing or maintaining agency remuneration, increasing worker remuneration, or balancing other goals with cost control.

DISCUSSION

Seven attributes of uncertified home care politics at the State and local level are highlighted by the data presented here. First, quality-related policies are the most prevalent on respondents' political agendas, with access-related policies the second most common, and cost-related policies last.

Second, there are real differences—and in some cases conflicts—in approaches to quality according to respondent type. Regulatory approaches to quality are most commonly promoted by trade associations and government agencies, both of which express concerns with expanding the scope of agency types regulated while maintaining flexible regulatory standards. Creating change at the level of the individual worker—generally through increased training—is most commonly addressed by local government. Change in the locus of control—particularly to increase the power of consumers—is most frequently a concern of disabilities groups who tend to oppose regulation.

Third, access concerns are much more common on private sector than public sector agendas, and are most frequently acted on by consumer/consumer advocacy groups. Fourth, the access issue these groups are most likely to address is an increase in public funding and service levels, particularly for home care support services. Fifth, few respondents are working to promote cost containment; most of those who are also wish to see cost containment balanced against quality and access concerns. Sixth, a number of respondents favor policies which require either a major restructuring of home care costs or an overall increase in spending levels. Seventh, organizations representing the elderly consumer are relatively uninvolved in this area of policy debate.

The next part of the discussion examines what these findings tell us about home care politics. The third part of the discussion addresses the implications for the policy analyst. The final section suggests future research based on this study.

Overall Political Climate

This study captures two key attributes of the overall political climate relative to uncertified home care at the State and local levels. First is the great interest of stakeholders in influencing quality-related policies. The relative prominence of quality-related policies on stakeholder agendas has four possible explanations, which are not mutually exclusive. First, these policies may be particularly relevant to the structural interests of key stakeholders, such as consumer groups and trade associations. Second, State and local respondents may believe that they have more capacity to affect quality issues than issues of access/funding and cost. Third, the concern with quality may be attributable to the perception that uncertified agencies, being unregulated, provide lower quality care. This belief, of course, is held by only part of the sample. A fourth and broader

interpretation is that the amount of political activity relative to quality-related policies reflects widespread concern about the efficacy and impact of current quality-related policy. Support for the last hypothesis is provided by the controversy over the proper approach to obtaining quality of care

The second major attribute of the political context is the challenge it poses to cost containment, despite increased scholarly, media, and policymaker attention to this goal in the larger health care field. More than twice as many respondents reported working on quality-related issues as on all cost-related issues. Many approaches to quality promotion (e.g., through high regulatory standards, increased remuneration of workers, or increased training) require either dramatic restructuring of costs—a politically difficult goal—or increased funding. Access-related concerns were also more prevalent than cost-related issues, and the majority of respondents cited funding problems as the barrier to access, requiring either an overall expansion of health care or home care funding or a reallocation of funds within those sectors. Examination of the cost-related responses makes the challenge to cost containment even clearer. Few respondents reported working to reduce costs, and all of these hoped to see cost balanced with other concerns. A number of respondents described cost-specific positions requiring restructuring and/or an increase in spending.

One reason for the paucity of activity to control costs may be that uncertified agencies are perceived as already providing low-cost care, since they do not have to meet Federal standards for staffing, bookkeeping, and other structures and procedures. It may also be that none of the major players perceives cost cutting to be a major interest or mission. If the latter were true, it could help to explain the difficulty of implementing effective cost-control mechanisms for home care.

The Configuration of Political Interests

One goal of this study was to understand the overall configuration of political activity, including who is not involved, as well as who is. The finding that umbrella organizations do not describe themselves as active in home care politics is not surprising given their non-profit status. The failure of State insurance departments is hard to interpret, given the even distribution of responses among "Does Not Apply," "Don't Know," and "Refuse to State." The clearest and most interesting finding is the relative lack of involvement in this area on the part of the elderly. One might expect that this can be explained by the coverage of the elderly by Medicare, presumably making them more likely to use certified than uncertified agencies. However, those 65 years of age or over constitute a majority of the clientele for both agency types: 73 percent for the certified and 62 percent for the uncertified (Linkins, Bradsher, and Estes, 1993). Thus, the elderly are affected significantly and directly by policies relating to uncertified home care. One possible explanation is that home care in general, while important to the elderly, must take a political back seat to the many other policy issues which affect them, such as Social Security or nursing home policy. An alternative explanation is Medicare's role as the unique, common, and primary source of health care funding for the elderly, making it a logical organizing issue. Whatever the reason, it is clear that the concerns of the elderly about uncertified home care are poorly represented in the political arena.

As expected, we find significant heterogeneity in terms of the frequency with which respondent types are working on a given

issue, as well as in attitudes towards some issues. In the quality arena, most stakeholder interests are quite active, and they shape themselves into a strikingly familiar configuration—one very similar to Alford's (1975) schema of health care interests. The trade associations promote regulation, which coincides with their interest in maintaining control of the home care market. Regulation is also promoted by government which is—Alford would probably argue—motivated by the mission of controlling the home care system. At the same time, a key segment of the consumer population provides a very different approach to quality in promoting consumer control. While this study has not tested the process by which political agendas affect policy, a working hypothesis based on this configuration of interests is that the common perspective of government and home care providers maintains a focus on regulation as a means of promoting quality. This hypothesis is not a criticism of regulation, but rather suggests that political dynamics maintain a narrow approach to quality.

An important caveat to using Alford's lens to understand the quality arena should be noted, however. Consumers in this context are not a monolithic group. The elderly, based on other evidence, place more faith in regulation than do the disabilities groups (Harrington and Grant, 1990). Nor is government entirely monolithic, as local government places more emphasis on the individual worker as the pressure point, while State government is more focused on agency structures and procedures.

The configuration of policy interests by stakeholder type relative to access and cost looks less like Alford's triangle than does the quality arena. Overall, consumers and providers seem to have a greater commonality of interests in these two areas than they do in the quality arena, since both are concerned with seeing funding and service

levels increase. Moving away from Alford to look at interest configurations more generally, one major cleavage is the frequency with which private sector respondents, and consumer groups in particular, work on access issues, suggesting that attitudes towards this arena may cross-cut all stakeholders, but that the most consistent voice for access will come from consumers. Finally, stakeholders have varying concerns relative to cost.

The Determination of Political Agendas

Looking at the broad parameters of the political interests represented in this study, we find that the respondents' positions generally correspond to their interests based on socioeconomic structures. For example, as existing theory would predict, the trade associations are simultaneously concerned with expanding the scope of home care agencies covered by regulation and increasing flexibility and maintaining separate tiers of services. Home care associations, in attempting to extend regulation to uncertified or unlicensed agencies, can be seen to be attempting to increase the costs of doing business for the previously unregulated, and, therefore, raising the prices they charge their clients. The interest of one trade association in the study in creating varied regulations can be interpreted as a desire to maintain distinct agency types and market niches, i.e., a way of controlling the supply of service providers.[7] Finally, once agencies are regulated, it is logical that they want to lower their own costs by relaxing the actual demands of regulation. Similarly, the relatively frequent concern of government payers with cost containment, and the concern of consumer/consumer advocacy

[7] A possible alternative explanation, that the trade association was acceding to demands of non-medical membership, is not borne out: 100 percent of the association's members are licensed.

groups with access issues are understandable given their material concerns.

Some further explanatory power is derived from occupational mission, explaining in particular the concern of government with regulation. The data also suggest a role for policy in shaping both actual and perceived interests and political concerns, a supposition which requires further testing.[8] Notable in the study is the particular emphasis of local government agencies on the training of individual providers. This emphasis is probably the result of their policy of using independent providers as well as agencies. However, it has potential implications for changing the focus of quality improvement even for agencies. This emphasis by local government points to the role of a specific policy context (in this case, the use of independent providers by local government programs) in shaping a respondent's policy focus. Similarly, a hypothesis emerging from this study is that the unique position of Medicare as a common concern of the elderly focuses the attention of interest groups more on certified care than uncertified; this would have to be tested by comparing agendas in the two areas.

Another factor conditioning interest group agendas may be the existence (or lack) of specific organized interests and their strength and history in a community. This may explain why California, which has the only significant union presence among uncertified home care workers of the three study States and is the home of the disabilities rights movement, is also the only State where respondents discussed the need to raise workers' wages and the only State where the issue of consumer control was raised by respondents other than disabilities groups.

[8]For theoretical background, see Berger, 1981.

Home Care Policy Analysis

The perspectives of the stakeholders in this study suggest different strategies for quality improvement in home care: agency-level regulation, worker-focused training, increased worker pay and benefits, case management, and consumer control. These alternatives warrant greater attention. Some of them are complementary. For example, creating monetary incentives for worker training above and beyond minimum regulatory requirements might not only create the possibility of improved quality, but also lessen the need to use penalties to ensure compliance with regulatory requirements for training.

There are also tensions between these approaches. The responses of the disabilities groups suggest a real paradigmatic difference in the understandings of quality underlying the regulatory and consumer-control alternatives. From the point of view of disability activists, consumer control is not only a means of improving quality, but a means which cannot be compensated for by the application of other types of quality assurance; it is only the consumer who ultimately understands his/her needs and the impact of caregiver actions. Activists see lack of consumer control as creating a dependency which is inherently degrading to the consumer. Thus, the very meaning of quality is different for these groups than it is within the framework of agency regulation.

To a lesser degree, the study also offers alternative perspectives on cost containment. Most obviously, the study respondents do not view home care primarily as a means of controlling health care costs, despite its historical role for Federal policymakers. Furthermore, some consumers and labor promote a restructuring of costs

within home care agencies and among home care provider types. The former is a particularly rare topic in current policy debates, and incorporation of this perspective would widen the terms of the debate from a goal of cost-effectiveness to an additional goal of appropriate remuneration of the home care labor force. Finally, some respondents concerned with access argue the need for a less medical paradigm of public funding and home care.

Policy analysts should not only be aware of these specific alternatives, but of the fact that different interests and different perspectives exist and will have varying degrees of representation and influence in high-level policy debates. Most notably, the elderly, who constitute the major consumer group for uncertified agencies, are relatively uninvolved in this political arena. Policymakers and policy analysts concerned about the impact of home care services on the elderly must take active steps to solicit their experience of, and concerns about, uncertified agency care through survey research, qualitative interviewing, policy forums, or other mechanisms. Furthermore, while this study does not analyze power differentials among the stakeholders who are active in this arena, other research on health care politics suggests that such inequities exist and that some voices will be harder to hear than others. Given the diversity of attitudes represented in this study, policymakers and policy analysts should aim to uncover and consider all the varying perspectives which are likely to be part of home care politics now and in the future.

Policy analysts should also be aware of the implications of stakeholder agendas for the political viability of policy solutions to health care system problems. For example, if policy analysts wish to fashion politically viable cost containment policies utilizing or

addressing uncertified care, they must find a way to engage stakeholders in discussions which generate new ideas and build support for packages of measures which will address stakeholders' primary concerns as well as the need for overall health care cost control.

The perspectives described here can also be used as an optic for understanding interconnections between policy issues. The Clinton proposal, for example, included a long-term care program for assistance with activities of daily living for the severely disabled and very young technology-dependent children. This long-term care plan would have offered the option of choosing either agency-administered, professionally managed, or consumer-directed, self-managed care. Consumer direction included hiring, training, and management of the home care provider by the consumer. However, the Clinton plan also promoted increased use of managed care and integrated health systems, and could easily have led to a much greater role for case management relative to the home care services provided under the reform's Basic Benefit Plan and through Medicare. Yet disabilities groups point out a potential conflict between case management and consumer control. Thus, even while the option for consumer control would be expanded for one set of beneficiaries, it might have been narrowed for others. The Clinton plan would not have established the principle of consumer choice or consumer control, but rather was a particular response to a particular set of political pressures from the disabilities community. While politics might have brought about this result, analysis of political agendas reminds us that managed care and consumer control need to be analyzed together.

FURTHER RESEARCH

The consistency of most response patterns across the three SMSAs studied here is compelling. However, future research might examine the political agendas of stakeholders in other locations. Given hypotheses about the origins of stakeholder policy positions generated by this study, it would be useful to examine locations where the presence/strength/history of organized interests varies (particularly the unionization of home care workers and the strength of the disabilities movement) and where the policy context differs significantly from that of the three study States. One dimension, based on study hypotheses, would be variation in public funding of uncertified agencies and independent providers. Given the importance of licensure as a form of regulation, variation in licensure laws is another important dimension of policy context. Another important addition to the study of stakeholder agendas would be an examination of national-level players. Finally, future research on political agendas may wish to examine the three respondent types poorly represented or excluded in this sample. Consumers represented by the disease-specific groups were generally numbered among the members of the disabilities associations. However, disease-specific advocacy groups may understand home care policy differently than the disabilities movement. Agencies and groups concerned with mental health/mental retardation would be expected to have special concerns relative to such issues as consumer control. Finally, insurance companies—while no doubt similar to government payers in some of their concerns—may have idiosyncratic viewpoints. While this study captures important political positions of the key stakeholders, new positions could be added to the picture.

Future research should also attempt to go beyond the study of agendas to understand their connection to the actual nature and outcome of policy debates. In particular, it is essential to understand which interests have the most influence on the policy process and what that influence is. A relevant hypothesis emanating from this study is that the common concern of home care providers and government agencies with agency regulation has led to the dominance of this approach to quality improvement in policy debates. A second hypothesis is that the relative lack of interest in promoting cost containment among stakeholders helps to explain the difficulty of passing and implementing cost control measures which are effective.

CONCLUSION

This study found substantial differences across stakeholder groups in both the frequency with which they work on given issues, and, in key instances, in attitudes towards these issues. Quality-related policies are the most prevalent on respondents' political agendas overall, followed by access-related policies. There are differences in stakeholder approaches to quality, which can be conceptualized according to Alford's (1975) schema of health care politics; providers and government are focused on a common strategy of regulation, while disabled consumers advocate an alternative paradigm of consumer control. However, intragroup differences were also noted, with local government more concerned with worker training than State government, and elderly consumers behaving different politically than the disabilities groups.

The cost and access arenas in general show a greater commonality of interest between providers and consumers than

does the quality field, although the cost arena shares some attributes of Alford's schema. The most notable difference in the access area is not in what stakeholders want, but how often they reported working on this issue. Access concerns are most frequently acted on by consumer/consumer advocacy groups, with their most prevalent concern being an increase in public funding and service levels, particularly for non-medical home care services.

Few respondents are working to promote cost containment. Most of those who do also wish to see cost containment balanced against quality and access concerns, and most respondents favor policies which require either a restructuring of home care costs or an overall increase in spending levels.

Based on this analysis, hypotheses for future testing include the connection between provider and government perspectives on regulation and current approaches to quality assurance, and the connection between the political context and the difficulty of passing and implementing effective cost controls. Further hypotheses concern the origins of the political agendas described here. These agendas are clearly rooted in interests based on socioeconomic structures, but the study suggests that they may also be influenced by symbolic concerns, policy context, and interest group presence and strength.

The stakeholder perspectives presented here offer policymakers and policy analysts alternative paradigms to home care policy, particularly in the quality arena. The basic inequities of politics and the attitude diversity described here suggest that policy analysts should actively attempt to solicit varying stakeholder perspectives. The concerns of the elderly, in particular, are likely to be overlooked. Furthermore, understanding stakeholder concerns reminds analysts of the interconnection of policy issues often dealt with in a compartmentalized fashion by the political process. Finally, understanding stakeholder concerns can enlighten policymakers as to areas where they actively need to engage stakeholders in discussion and negotiation in order to cultivate support for policy efforts.

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