Do We Change the Market or Does the Market Change Us?

Cooperative Home Care Associates in the New York City Home Care Market

by

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B.A. Social Studies, Harvard College
(1975)

Submitted to the Department of Urban Studies and Planning
in Partial Fulfillment of the Requirements for the Degree of

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Abstract

Cooperative Home Care Associates (CHCA), profitable and growing after nine years, has succeeded in the marketplace with an unusual business strategy that balances social goals, profits, and delivery of high quality patient care. In this thesis, I look at CHCA in the context of its market to understand its opportunities and constraints, and to consider the interface between the internal and external strategies of a progressive firm.

I argue that in this market, the government is buying a service (home care) and jobs (many home health aides have been on welfare). While CHCA is linking these two interests successfully by pursuing both quality of patient care and improvement of working conditions, the market structure as a whole does not foster these interests so well. Another progressive agency in the market, the Visiting Nurse Service of New York (VNS), has developed a rating system for its home health care subcontractors to improve quality of care. While finding this new system innovative and promising, I argue that the structure of the market limits this initiative as well as CHCA's, and also that the VNS's approach is limited because it does not link quality of care to improved working conditions for home health aides.

By looking at the market structure and especially the dynamics of its subcontracting relationships, I propose that we can better understand how the home care market could serve public as well as private purposes, how to make decent jobs a goal as well as good patient care, and how we could improve the quality of both care and jobs.

Thesis Supervisor: Dr. Richard Schramm
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Chapter 1 Introduction

Coming of age in the early 1970s, I and many of my fellows looked around the United States and saw not the "Leader of the Free World," but a nation riddled with contradictions. In a rich nation, grinding poverty persisted through generations; in a free nation, political dissidents, black Americans and many others were not accorded the protection of the law; in a democratic nation, the poor seemed unable to get the government to address their needs except by rioting.

We struggled, however, to find frameworks with which to analyze our world and guide our actions. In my twenties, I could not grasp a "big picture" explanation that satisfied me, though I had many strong opinions on individual issues. I took action only on a personal scale; I became a carpenter, and later an estimator and project planner for a large commercial general contractor. Learning the trade and the business was a pleasure in itself and also made a statement about one of my strongest personal beliefs, that women were unjustly denied access to many kinds of jobs.

Now, almost twenty years later, I am seeking to work on jobs and justice in a larger framework. Perhaps at forty-one I am more resigned to the dilemma of taking action without understanding everything. At MIT, I have studied regional economies, searching for answers to why some people can't get jobs and what makes a regional economy generate good jobs. I found myself drawn to questions of ownership and rights in the economy, and to research on worker-owned firms. I also came to the conclusion that the paradigm of the free market versus the planned economy is false; every economy is a "political economy" and we have not yet found an economic

model that gives working people the same rights that they have in our polity (that some have, anyway).

While looking for a topic for my thesis, I was fortunate to hear about Cooperative Home Care Associates, a worker-owned firm in the South Bronx in New York City that employs Latina and African-American women from the inner city as home health aides. The firm impressed me for several reasons. It employed over 300 people, a much larger company than most cooperatives and other community development enterprises. Furthermore, not only was it making a profit, but it was nine years old - a grandmother among start-ups. A large majority of its workers were buying a $1,000 share with weekly deductions from their paychecks and were thereby entitled to vote for worker representatives on the Board of Directors and receive yearly dividends, and 80% of these worker-owners had been on welfare before they joined the firm.

The managers of this cooperative work toward several innovative goals. They set out to improve the quality of very low-paid, lousy jobs within the constraints of the market (with some help from progressive foundations and loan funds). They undertook the responsibility of start-up and ongoing management, while devising ways to bring workers into a participative culture and to shift control of the board over time to the workers. With a unique training program for new hires, and high standards for all patient care given by company employees, the company fostered a culture of pride in people's work. And the cooperative's management constantly works on articulating their strategy clearly, and on seeking to influence the home care market through the example of their "best practices" for both patient care and working conditions for home health aides. This successful company model is now being replicated with

foundation funding assistance in four other cities.

In our initial conversation about research topics for my thesis, Rick Surpin, the President of CHCA, told me that he was struggling with the issue of his position as a subcontractor in the home care market; his firm provides home health aides (paraprofessionals) to nursing agencies who supervise the cases and receive insurance reimbursements. The nature of these subcontracting relationships, he felt, was limiting what he could do to further CHCA's mission of creating better jobs and influencing the market.

My construction days working for a general contractor taught me that subcontracting is indeed difficult. I lost arguments about treating our subcontractors as a part of our team instead of pushing them around to achieve our goals, though I was convinced that subcontractors had a gold mine of information that we could use to make projects run more efficiently. Progressive construction contractors toy with these ideas, but when push comes to shove firms generally go back to basic self-interest and leave the teamwork ideas behind. Nor would it be easy to move beyond this structure; the expectations of clients, architects and other construction companies are that teamwork may easily equal collusion, and they are not unjustified in worrying about this. How can they know that they are getting a fair price if they don't mediate the relationship between the general contractor and the subcontractor through the bid process? Yet how can we evaluate the real costs of inefficiency due to lack of teamwork throughout the long process of design and construction?

With these thoughts in mind, I set off through a snowstorm on the first of three trips to New York to interview CHCA staff and eventually representatives of other nursing agencies (contractors) and home health aide agencies (subcontractors) on

CHCA's business strategy and on how the home care market is structured and what effect that has on its functioning. While I have only learned a bit of what there is to know, I have come to think that the subcontracting issue and the structure of markets more generally truly are important issues to consider when evaluating such an innovative firm or trying to develop more firms like it.

Methodology

My work on this project has been qualitative, using interviews to ask people to describe their perceptions of the market, of their agencies and of each other. While I think that a larger study to gather more objective data would be a valuable addition to the picture and possibly challenge some players' perceptions, this thesis limits itself to a synthesis of my interviewees' descriptions. All the people that I interviewed were sophisticated business people and significant players in the market, and their comments were extremely enlightening to me. I am grateful for their time and attention.

My contribution to understanding CHCA's impact is to examine CHCA in the context of its market, to lay out the opportunities and constraints the market presents to such a firm, and to speculate on possible changes in the market structure that could encourage more such firms. To create a framework for my discussion of CHCA in the home care market of New York City, I will first describe CHCA itself, then explore theories of markets from which we can draw some useful ideas. Following chapters will go into more detail about the home care market's structure in New York and about specific features of CHCA's subcontracting relationship with its major

contractor. Finally, I offer some analysis based on my observations, and recommendations and conclusions. I begin with a brief history of CHCA.

Cooperative Home Care Associates

Cooperative Home Care Associates, founded in 1985, was a venture with several agendas.[1] Rick Surpin initiated the cooperative as an economic development project of the Community Service Society (CSS), a private social service organization. He and his team picked home care for their proposed business because it was a growing market and offered jobs accessible to city residents with few job skills. Poor job conditions prevailed in the industry; home health aides were paid minimum wage, got no benefits and generally worked only part-time hours, as most cases were assigned morning hours only. The new cooperative's strategy was to offer not only the benefits of worker ownership but a substantially better job than the industry average. Paying better wages and benefits would be financed by providing better quality care and winning contracts with sufficient volume to gain economies of scale on administrative costs. Full-time hours would be found for most of their employees. The multiple agendas of CHCA, then, included creating a worker ownership model for a low-wage industry, becoming a profitable business, improving working conditions, and offering a better service - a lot to take on.

The cooperative got started with assistance from CSS and other progressive loan funds and foundations. One nursing agency, the Montefiore Home Health Agency, agreed to assign cases to CHCA, on the premise that it could provide better care

[1] CHCA's history is summarized from two case studies, "CHCA: History and Lessons" 1993, and "CHCA: From Working Poor to Working Class Through Job Ownership" (see bibliography).

because its worker-owner aides would stay with the firm and provide consistency for patients. Montefiore administrators were particularly concerned about the inconsistent care their patients were receiving from their largest contractor at the time, so they had nothing to lose in trying out this new firm to see if their strategy worked.[2]

In spite of careful planning and high hopes, however, the cooperative floundered for over two years. CHCA promised its workers the highest wages in the city and full-time work, but was then unable to secure enough afternoon case hours to deliver on the full-time work. Sales lagged behind projections, good managers for a cooperative proved hard to find, and finances became increasingly tight. Rick Surpin, who had remained on staff at CSS during the start-up, was forced by the firm's desperate straits to take over as CEO. He spearheaded a turn-around that brought the company into the black by the end of 1987, delivering better quality care as promised and increasing hours so that 70% of CHCA's aides were able to work full-time.

The ownership structure of the company evolved during the first few years. Originally, workers were expected to become members after they finished a probationary hiring period, buying a share through payroll deductions over five years.[3] Their yearly profit shares would be distributed partly as cash dividends and partly into

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[2] Contracts between nursing agencies and home health aide agencies are very open-ended; they include a rate that will be paid and basic conditions to be met. No promises about volume of work are made, and either party can terminate the contract with thirty days notice. The nursing agency is not obligated by the contract to actually assign any work.

[3] The membership structure was modelled after the Mondragon cooperatives in Spain, whose long successful history is based in part on an ownership structure that allowed new workers to buy in at the same share value, and kept internal membership accounts so that each member held a share of the undistributed profits according to the amount of hours they had worked.

a membership account held by the cooperative until the worker left the firm. An early problem arose; the firm was losing money and its generally part-time employees had no interest in buying in. Ownership was made a choice for all workers, and the cooperative undertook a membership drive to recruit worker-owners after the company began to make money. The Board of Directors initially included managers and funders, and shifted slowly toward a majority of worker-owners as the cooperative structure took hold. This recognition of the realities of ownership demonstrated the commitment and flexibility that has marked much of CHCA's business strategy.

Getting the finances into the black required getting more sales and expanding beyond their original contract. Montefiore, under a new administration, gave no rate increases for three years in a row, putting a strain on CHCA's high wage strategy. CHCA landed a new contract with the Visiting Nurse Service of New York (VNS), by far the largest nursing care agency in the city, on the basis of CHCA's reputation for quality care, even though the agency was smaller than the VNS's average subcontractor. The VNS paid higher rates than Montefiore and had a large caseload, allowing CHCA to pick up more and more high-reimbursement cases and cover their increasing wages, a critical component of their business strategy.

Over the next few years, CHCA experienced several significant changes. Management personnel came and went, although an increasing core of successful cooperative managers settled in. Key staff developed an in-house training program and obtained independent funding for training from federal Job Training Program Administration monies. The training program allowed CHCA to train new aides in the basic skills required for certification, in the special quality of care that CHCA offered, and in participation in CHCA's unique governance structure. CHCA extended the

minimum two weeks of training for certification to three weeks.

In 1990, based on advice from a management consultant on strategic planning, the cooperative's management decided to expand the company substantially. Although this difficult decision required adding staff to the management group, securing additional working capital, and accepting less close involvement with aides for the top managers, the consultant convinced management and the board of directors that CHCA could only achieve its goals of better working conditions and higher wages through expansion. The cooperative increased from about 170 aides in 1989 to almost 300 in 1992, and continues to expand at about 40 aides per year (limited by the number that can take the training program in a year).

CHCA's strategy of better working conditions depended largely on better service; one index of their success at both has been their turnover rate. Low turnover means that the company is able to provide more consistency to patients and to the nursing agencies who supervise the cases. It also indicates satisfaction on the part of employees. In 1985, the industry average turnover was about 60%, while CHCA's was about 25%. Turnover at CHCA remained at about 25% for the first several years, then dropped further to 11% in 1992. The industry average is now around 40%, and another large home health aide agency I interviewed was proud of their turnover rate of about 25%.[4]

As part of their strategy to pay high wages and benefits, CHCA has made efficiency on office overhead a priority wherever it does not affect quality of work or quality of care. A computerized office management system was developed to

[4] Interview; Flannery, Partners-in-Care.

streamline paperwork and case assignments, and managers frequently review in-house administrative procedures to make improvements. On the other hand, they spend a huge amount of time on interviewing prospective aides, selecting about one in four applicants. Managers see this investment of overhead time as critical to getting the right staff to provide quality care.

Managing home health aides who work dispersed throughout the city in people's homes means that managers must communicate well by phone and at infrequent in-house meetings with aides. Involving aides in the company's management and in elections for the Board requires constant effort to reach out to them; extra meetings after work hours are hard for workers who must travel to the office after their case work is done, and who are often single parents with many responsibilities at home.

The cooperative has continued to make good on its pledge of high wages and benefits (for the industry). As of the beginning of 1993, the cooperative offered $6.00 an hour starting wage (compared for instance with $5.50 starting wage in 1994 at another large agency[5]), $6.50 for one year seniority, and $6.70 for three years seniority. Aides working weekend hours and difficult cases (AIDS, quadriplegics) received differential pay. Aides received health insurance, vacation and sick days, and a uniform allowance, as well as a share in profits (cash dividends have amounted to upwards of $500 per worker-owner).

A nursing education program was established to offer aides a chance to move up the job ladder, and within the firm more senior aides were offered a commitment of 30 hours minimum per week, and opportunities to become team leaders. These steps

[5] Partners-in-Care

represent an effort to create some kind of career ladder, as home health aide jobs generally offer no advancement opportunities.

Though it is a small player in terms of size, CHCA has influenced the New York home care industry. It has received national as well as local recognition for its unique strategy and its success in improving the lives of its workers. Surpin founded a city-wide Working Group on home health care issues that successfully urged the legislature to increase reimbursement rates to allow wage increases. The firm is known for its high quality, and is asked by contractors and even competitors about its practices. Most of all, it is a special place to work.

Why Look at the Market?

What, then, are the elements of CHCA's strategy that work so well? It is efficient, not only in the conventional sense of careful management of its resources toward production of its services, but in the social sense that the resources are distributed where they will make the most social difference. The government monies for Medicare and Medicaid that trickle down to CHCA support various bureaucracies and institutions and generate profit for individual owners of firms along the way, but when they reach CHCA the percentage that goes to workers jumps because they receive both wages and profits. More than profits, they get respect and the entitlement of ownership in their company. Since the people who benefit are working poor and largely disenfranchised residents of the inner city, the importance of this difference cannot be overestimated.

On a larger front, CHCA and its market are at the nexus of three policy issues that are being hotly debated--economic development for the inner city through market-

driven solutions, welfare-to-work transition policies, and health care reform. CHCA's internal strategies and practices are worthy of more attention (which others are giving it), but in order to understand the full impact of their example with regard to these policies, we must look at how the market presents barriers and opportunities for their unique strategy of combining social mission and business survival.

In looking at CHCA in its market context, I am not simply looking at companies with whom it competes and with whom it contracts, but at a system of relationships, incentives, understandings and assumptions. This market is distinctive in many ways, particularly because it has so much government and institutional involvement and because the majority of its workers (home health aides) work in homes by themselves, not in workplaces. Nevertheless, literature about economic organization and competitiveness offers concepts often drawn from studies of manufacturing industries which can be applied to this low-wage, low-skilled service sector. Envisioning these jobs as part of a revived and competitive U.S. economy is a new slant on service work that I will argue is worthwhile. My hope is that by understanding the home care market, with this firm as the basis of a case study, we will be able to frame policies that will improve the lives of more workers and more patients than CHCA can reach alone.

Chapter 2 A Framework for Discussion

As the home health care market in New York grew rapidly in the late 1970s and 1980s, pressures to cut costs pushed the market toward a configuration with paraprofessional (home health aide) agencies functioning essentially as temporary help agencies. These agencies kept a roster of names, dealt with aides largely over the phone, and paid minimum wage on an hourly basis. Aides, in turn, often put their names on several companies' lists to increase their chances of getting work. With this labor management system, not surprisingly, quality of care deteriorated.

CHCA's managers developed their business strategy by focusing on the relationship between good working conditions for employees and high quality of service. Home care is not like fast food, where a few hours of training and close supervision establish and maintain a desired quality of service. Home health aides work individually with sick and frail people in their homes, in a relationship that is both very personal and transient. Providing good care means not only understanding the basics of personal care and simple medical procedures, but handling expectations and emotions, exercising judgment and, it is hoped, offering kindness as well as physical care. CHCA's strategy was to create a high end niche in the market by providing high quality care; in return for high quality service they would ask for more afternoon hours to allow their aides to work full-time and enough volume to pass their break-even point rapidly. Once they were profitable, they could manage their overhead closely to pay higher wages as well as pay dividends to their worker-owners.

In this thesis, I will argue that CHCA's strategy of focusing on quality of care by linking it to the quality of working conditions is a critical lens for looking at the entire market. This is the intersection point for the policy questions of economic development, health care reform, and welfare-to-work transitions that I raised above. To frame this argument, I look first at the market in terms of the government's expenditures in it; since the government pays the bills for most home care through Medicare and Medicaid, they are in a sense the customer. I argue that not only should the government buy good quality of service for its money, but it should also buy decent jobs. Eighty to ninety percent of CHCA's new hires over the years have been women on welfare coming back into the workforce; these jobs are accessible to women with little work experience or education. The jobs created by the market structure, however, became so poor that it was virtually impossible for women to stay securely in the workforce. Therefore, the government spends welfare and training funds cycling women through the welfare system, while spending health care funds to support a market structure that virtually creates dependence on welfare for the majority of its workers.[6] Thus, the true interests of the government are not being fully served by the market's current configuration.

The government uses the "high-powered incentives" (Williamson 1985, 90) of the market to purchase home care services with the hope that the market will be more effective and efficient than the government itself would be. However, as I examine this market in more detail, I will argue that some actors in this market meet more of

[6] The irony of this position can be seen in a situation that I will discuss further below; the government is threatening to withdraw funds from CHCA's training program because they are unable to place their trainees in jobs making a minimum of $8 per hour. No other criteria are being applied to the jobs except this wage floor.

the true purposes of the government than others, that some make quality of care and/or quality of working conditions more of a priority than others. Given that some, like CHCA, use market incentives to meet more social goals, how can we think about both government policy and market structure that would encourage more such agencies throughout the home care system?

Drawing on different aspects of the literature on markets and firms, I will first argue that the government has wider latitude than is generally accepted to shape the structure of markets to meet more social interests. Then, I will draw out some concepts from the literature on competitiveness that apply to improving quality of service through new practices and institutions in the market. Later, after more specific discussion of the home care market in New York City, I will argue that the practices and institutions discussed under the rubric of competitiveness can also be used to take advantage of market incentives to serve public interests more successfully.

Theories About the State and the Market

Neoclassical economic theory, which dominates U.S. public policy thinking, asserts that the market and the polity are fundamentally separate spheres; hence government actions to regulate or limit market actors distort the market's functions and lead to less optimal results for both individuals and society. Other traditions in economics and sociology see the market and the state as fundamentally interlinked, or as two spheres with a membrane between them.[7] I have drawn from theories on property rights and economic sociology more generally for concepts that support a

[7] A phrase used by Professor John Campbell, Sociology Department, Harvard University, describing theories of Fred Block.

view of the state itself as an actor in the market, from which we can return later to discussions of how the state might participate in the home care market as more than a bills-payer and regulator.

John Campbell and Leon Lindberg's analysis of "Property Rights and the Organization of Economic Activity by the State" (Campbell and Lindberg 1990) argues that the state and other economic actors interact continuously, responding to pressures from each other by testing new forms of economic organization and establishing new property rights. By property rights, they mean

> "state activities that define and enforce property rights, i.e., the rules that determine the conditions of ownership and control of the means of production. Examples of property rights actions include the establishment and enforcement of antitrust, regulatory, labor and contract law." (p.635)

Property rights are more than a legal framework; they "also express relationships among people" (p.635), and the negotiation of rights happens in the political as well as economic arena.

Campbell and Lindberg's article provides a complex and flexible view of the state's involvement in the economy, as actor and as institution, interacting with many private players through a variety of channels. They emphasize that "the state's ability to define and enforce property rights determines social relations, and therefore, the balance of power among a wide variety of economic actors in civil society" (p.636). Accordingly, actors in the home care market, including the state itself, can enter the market with specific objectives around jobs and quality and attempt to negotiate the "rules of the game" toward those ends. Examples of such negotiations could be a class action lawsuit by an advocacy group over a quality of care issue, or the CHCA business strategy, or the City-Wide Working Group proposing a government regulation

requiring that agencies provide full-time work to 70% of their home health aides.[8]

Fred Block, in an essay on "Political Choice and the Multiple 'Logics' of Capital" (Block 1990), cites the work of Karl Polanyi to make a similar argument that there is no fixed relationship between economic and political forms, but a constant interaction of the state and individual economic actors and institutions (p.297). Because government policies are "not superstructures built on top of some economic base [but] rather, they are constitutive of the capitalist economy" it follows that "some government policies are more effective than others, but the explanation for less effective ones has to be sought at a more concrete level of analysis than interference with the basic logic of the economy." (p.298)

Block also argues in this essay that framing the questions themselves is key to the answers you can find; in the case of the home care market, I argue that if we do not raise the issue of multiple government agendas (care and jobs) the market will not perform up to its capability. Furthermore, building on both Block and Campbell and Lindberg, raising such agendas is not "interfering with the free market" but seeking alterations to the current state and market relationships that would cause new practices and institutions to evolve to will represent a different and better balance of power among the players. In the case of quality of care and quality of jobs in the home care market, we are looking to include the interests of two largely disenfranchised groups, patients and home health aides.

While the quality of both patient care and paraprofessional jobs affects the public welfare, the traditional pressures for quality--consumer choice for patients and labor

[8] Hypothetical examples except CHCA's business strategy.

organizing for workers--do not operate well in this market. Patients do not choose their caregivers, and many are afraid to complain if they are given bad service.[9] Home health aides have low expectations and few options, and they have no common workplace because they work in people's homes. They are isolated and dispersed, and very hard to reach. Given these characteristics of the market, choices of such actors as the agencies and the government become more important; these are the actors that can make changes happen. Taking Block's advice to heart, I will look below at the "concrete level" of the existing regulations, incentives, firms, relationships and quality of outcomes of the market to develop recommendations and strategies to further social goals as well as efficient markets.

John Parsons (1989) makes an argument that the state's economic interests extend farther into the firm as well. In "The Riddle of the Limited Liability Corporation" Parsons points out that the state ultimately stands behind liabilities incurred by the corporation; for instance, an environmental disaster costing more than the firm's total worth will become the state's liability. The state, however, in spite of its interest in the ultimate outcomes of the shareholders' decisions, has no voice in that process. "We argue that this off-balance sheet liability held by the state needs to be properly managed if the prerogative of the shareholders to make the investment decisions of the firm is to *serve the common welfare*" (p.2, emphasis added).

Parsons outlines the relationships of stakeholders (those with any interest or claim against the corporation whether recognized on the balance sheet or not) and shareholders (those with formal ownership rights) and argues that there are a number

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[9] Home care is not the only sector with these kinds of issues; other public services and health sectors, for instance, often have the same separation of consumer and payor.

of significant claims against a corporation that go unrecognized by our legal and accounting systems. In the home care market, the costs of underemployment and welfare created by the market structure would be an example of the state's ultimately bearing the costs of decisions made in the corporation.

Yet, firms can include more stakeholders in their decision-making process. CHCA has included their aides both through management's ongoing efforts to improve quality of work, and through the more formal mechanism of worker ownership and participation on the Board of Directors. CHCA also takes the patients' interests into account by linking the quality of care with the quality of working conditions, though patients have no formal voice in the firm. Customers traditionally have voice in a firm through purchasing choices; in this case, CHCA has to ask patients how they feel about the service, and make sure their aides understand what they can do better for all their patients.

From this discussion of the interests of the state in quality of care and of jobs in the home care market, and of the potential range of actions open to the state as an actor in the market, I go to a discussion of competitiveness in order to focus more specifically on literature about how markets and firms achieve good quality products and processes. Much of this literature also explores the nature of the membrane between the state and the market, and the question of how market incentives and public purposes interact in different policy frameworks.

Theories About the Organization of Markets and Quality Outcomes

The home care market is a labor-intensive service industry; home health aides who are semi-skilled paraprofessionals work in people's homes with little supervision,

often on cases that are relatively brief. Many of the people served are poor and/or elderly, particularly in a large city like New York. From an outside perspective, it may seem that quality issues would be relatively minimal and that cost efficiencies would be largely in keeping the cost of labor down and minimizing the hours assigned to patients. From my observations, however, quality issues ranging from lateness and lack of coverage on cases to abuse of patients and abuse of aides are significant, and many managers in the industry take these seriously. Cost efficiencies in terms of total cost do lie largely with the amount of assigned hours and the wages paid, but careful management can produce a different equation of quality and production by maximizing the attention paid to quality and by minimizing overhead costs in order to pay aides better wages.

Within the home care market, however, there are clearly firms and institutions whose profit incentives and internal strategies detract from careful management of quality of care and quality of jobs, and others who are responding to this challenge more successfully. In the next chapter, I will describe the structure of the market in more detail, but in this section I will explore what the literature on markets and firms offers us for thinking about the home care market and how to make it more effective in producing better care and better jobs.

Looking at the home care market in terms of quality, efficiency and innovation, we can draw on a large body of literature that addresses the loss of American manufacturing's competitive edge in the global market over the last two decades. The literature that applies well to the home care case emphasizes the importance of contracting relationships among firms in fostering quality, and the diversity of forms of these relationships.

A general consensus emerges in the literature that large firms are no longer considered the inevitable leaders in competition for global markets. While some remind us that mass production is not to be ignored and will continue to play a major role in economies (Harrison 1993; Best 1990), interest in successful smaller firms has driven recent inquiry into the organization of markets. Smaller firms are touted as having the flexibility to respond to changes in demand more quickly, and the ability to combine forces in alliances either with other small firms or with large companies they supply to contribute their specialized production knowledge and technology to the development of new products and processes (Piore and Sabel 1985; Best 1990).

In the home care market, there are a number of paraprofessional firms, though not the small flexible firms of the literature referred to above. The VNS, on the other hand, is the largest nursing agency in the country. It controls such a significant portion of the market that its relations with its subcontractors are key to understanding how this market functions. Theories that address the kinds of subcontracting relationships between a large buyer and a range of smaller suppliers are therefore of most relevance to us.

Oliver Williamson put the question directly, "Why can't a large firm do everything that a collection of small firms can do and more?" (Williamson 1985, 131) His answer was that some kinds of transactions lend themselves more to efficiencies through market relationships (contracting), while others are better governed by internal hierarchies. Essentially, the market offers "high-powered incentives" while hierarchy has "access to distinctive governance instruments." (Williamson 1985, 90) In looking at the market structure in more detail below, then, we may question how incentives work in this market, and whether governance issues make separate paraprofessional

agencies a logical outcome.

Michael Best distinguishes firms not on the basis of size, but on the basis of their strategic orientation--whether they are entrepreneurial or not.

> "... the entrepreneurial firm does not seek to maximize profits simply by minimizing costs but seeks strategic advantage on the basis of Schumpeterian innovation in product, process or organization...the goal of the entrepreneurial firm is to gain strategic advantage by continuous improvement in process and product; the goal of the hierarchical firm is to gain minimum production costs by continuity in production operations, product runs and product design." (Best 1990, 11-12)

While the language here is the language of manufacturing, we can apply Best's distinction between entrepreneurial and hierarchical firms to home health care. CHCA is clearly an entrepreneurial firm, as their entire strategy is to continually improve their management and training to economize on overhead costs and improve working conditions while providing the best quality care. Their approach requires that they pay attention to individuals, whether patients or aides, to get the best match in circumstances, and even personalities when possible, rather than follow the temporary help service model that has been typical of the market, where calls are made down a roster of aides until someone can accept a placement.

Their strategy, however, requires a matching concern for quality in their contractors, particularly as their high wage strategy requires them to get high reimbursement rates. Currently, the VNS's rates are sufficiently higher than many other contractors that a large volume from the VNS, combined with economical overheads and lower profit levels, allows CHCA to pay higher wages within the constraints of the market. As I will discuss below, however, the VNS's concerns about quality, though real, do not match up with CHCA's business strategy completely, creating constraints for CHCA.

The question is whether the home care market supports an entrepreneurial orientation, in Best's sense of continuous improvement of quality, or a low-cost, production-run type of strategy. Below, we will look more closely at the VNS and its relationships with subcontractors; I will argue that the VNS falls somewhere between an entrepreneurial firm and a bureaucratic one, and that how it chooses to proceed in the next few years will have a big impact on the possibilities for entrepreneurial firms like CHCA.

Best (Best 1990) emphasizes the importance of external relations as well as the internal orientation of the firm in the pursuit of quality and the "new competition." "Efforts by a single firm to break out of the extra-firm institutional matrix of the old competition require a Herculean effort compared with establishing a firm within an already existing New Competition institutional configuration." (Best 1990, 21) Thus, while the firm's own culture and orientation are key to the success of competition on the basis of quality and innovation as well as cost, the sector is also vital to the long-run success of entrepreneurial strategies.

> "A sector can include a variety of inter-firm practices and extra-firm agencies such as trade associations, apprenticeship programs, labor education facilities, joint marketing arrangements, and regulatory commissions, each of which facilitates inter-firm cooperation...From this viewpoint, firms not only compete, but they can also cooperate to provide common services, to shape 'the rules of the market game', and to shape complementary investment strategies." (Best 1990, 17)

Common to Best's argument and to those of other theorists (Piore and Sabel 1985; Porter 1985) about new forms of competition that rely on quality is discussion of the paradox of competition and cooperation. These writers bring out the fact that low-bid contracting and low-price marketing strategies do not tend to produce the best quality results. Best comments that price wars destroy the ability of local firms to

build the infrastructure they need for quality competition in the global market. (Best 1990, 18) Porter describes the competitive advantage that some nations achieve with demanding regulations on such difficult issues as environmental impacts, and considers both sophisticated consumers and a strong group of suppliers and related firms as prerequisites to competitive advantage. (Porter 1985)

Ronald Dore cites Harvey Leibenstein's concept of X-efficiency as a savings achieved through best practices in business, a lack of "sloppiness" (Dore 1992, 172). X-efficiency can outweigh low-bid price efficiency in relationships with suppliers and subcontractors, though it is hard to quantify except by comparing performance with other companies. A recent article comparing Toyota and GM's practices with suppliers points out that GM spends five times as much on overhead to purchase about two thirds as many components because of their low-bid, arm's length relationships compared with Toyota's more cooperative and reciprocal relations with a much smaller number of suppliers. Toyota's success in the global market, and the relative quality of their cars compared with GM's, suggests that there may be more to these relationships than price.

The kinds of efficiencies that are realized by the "new competition" are generally rooted in the production process itself; through mutual design of products and through intimate knowledge of each other's operations, cooperating firms and suppliers can save administrative, inventory, and quality control costs and improve the process and product together as they go along.

Cooperation and competition are not easy to manage together; Best mentions the fine line that governments walk in trying to foster both, and firms must also struggle with this fine line. How they get put together also varies greatly in a number of

examples from around the world. The most commonly cited examples in the literature are the small networked firms of the Third Italy, and the large Japanese firms with their close-knit supplier relationships. The structures that hold these relationships together are very different, and are not easily reproduced across different industries, historical situations and current practices. Nevertheless, my argument, and that of many others chasing this idea, is that by looking closely at an individual market in a particular context with these ideas in mind, we can look for solutions that benefit from these examples.

A framework that usefully brings out the complexities and possibilities of contracting relationships is that of Bradach and Eccles (1989). They differ with the continuum between market relationships (price competition) and hierarchy (vertical integration) laid out by Williamson (1985), and instead pose three "control mechanisms" that they argue function independently and in combinations in various kinds of contracting relationships. What they offer is a way to look at cooperation-competition relationships with a flexible typology. The control mechanisms of price, authority, and trust, they argue can be combined in a variety of ways, both between firms and within firms. Price matches market, referring to relationships based on bid contracts and competition; authority matches hierarchy but refers more broadly to power relationships; and trust matches the forms of contracting that imply more reciprocal and long-term relationships. One can compare the difference, for instance, in the use of control mechanisms by Toyota and GM. Not only could Toyota be called an entrepreneurial firm in Best's terms, but it can be described as having contracting relationships that combine authority (in the sense that Toyota has tremendous power over its market and all its suppliers) and trust, because Toyota

maintains a reciprocal relationship with suppliers. Price enters in as well, as there are expectations of fair prices, and of the ability to reduce prices with increasing efficiency over time that, if violated, can become reason to discontinue a relationship. With GM, while price is obviously the dominant control mechanism with its suppliers, the importance of authority, GM's ability to dictate terms because of its size even without vertical integration, cannot be overestimated. Bad decisions on GM's part about how low to drive price can put suppliers out of business for good, not necessarily to GM's benefit.

In the home care market, the VNS also has authority, the ability to make or break paraprofessional firms. It can dictate terms to a large extent, and therefore its choice relative to other control mechanisms is crucial to the actual complexion of the market. If low-bid becomes its credo, the market will no longer support entrepreneurial firms like CHCA; if quality and innovation become its strategy, then the question of whether it encourages quality with an authority and price strategy or an authority and trust strategy makes a big difference.

I find Bradach and Eccles' ideas to be a useful addition to Best's ideas on cooperation and competition, because they give us a descriptive framework to apply when looking for the possibilities that Best so clearly describes in his book.

The last issue to touch upon among theories is that of what makes markets take one shape or another, and especially what makes them change. Campbell and Lindberg (1991) summarize theories that have been put forward to explain change in governance regimes in the market, and characterize them under five headings: economic efficiency, technology development, power and control, culture, and state policy. Each of these has proponents, and each tends toward a deterministic

explanation of the evolution of governance regimes. Campbell and Lindberg, however, step back from these five categories of explanation to pose instead a model of the process of change. Recognizing that each of these competing explanations has merit and appears to dominate in some situations, they theorize that changes in the economy, emerging for whatever reason, cause a search process to begin, whereby all the players in the affected market, including the state, search for alternative organizational forms that will adjust to the changes in the market. Through the experimentation and the political negotiation process of the interested parties, depending on their relative strength, success in mobilizing support, and so on, a new governance regime emerges until the next challenge.

When I look at the home care market, I see a market that is relatively new, and still very much in flux. What I will explore through my case study will bring out points that seem to both support and contradict positions such as Williamson's that attempt to find a single dominant causal factor such as efficiency. What we will see is that the influence of various parties is critically important, and the nature of pressures from the environment will also shape this market substantially--national health reform alone will have an incalculable effect when it finally happens. Bradach and Eccles give us a way to describe what different forms look like, but Best and Campbell and Lindberg give us rationales for action; the strategic firm, the strategic sector, the evolution of governance regimes through a search process--these are ideas that allow us not only to examine the home care market but to take some kind of stand on possibilities and their relative merit, and to propose which actors may be able to achieve significant results.

This review of theory has brought out the following issues for me:

1) To evaluate the success of an innovative firm, we must also understand the market around that firm, as no firm can succeed on its own in changing the market's operations.

2) Large contractors in a market have several choices for shaping their relationships; theory comes down on the side of more cooperative and reciprocal relationships to achieve quality.

3) Understanding the production process in detail is very important to reform and change; it is not through outside interference but through close examination of production process and product that firms, and scholars, understand how improvements can be made.

4) Efficiency is a much broader concept than low-price; to evaluate a social service system's efficiency, where price and consumer choice are less active mechanisms, we must undertake evaluations that get at the X-efficiencies of the system--the interactive effects of government spending in the market, market structure and the spillover costs and benefits on the larger social balance sheet.

5) The state in the U.S. has more power than is generally recognized to shape markets through its property rights actions. Changes in the structures of markets (governance regimes) come from many sources; a "search process" of experimentation and negotiation in the political arena determines the outcomes.

In the next chapter, I will describe the structure of the home care market in New York City, focusing on aspects of the contracting relationships that constrain what CHCA can accomplish, and on overall efficiency and outcomes with regard to quality of care and quality of jobs. In the following chapter, I will look in more detail at the relationship between CHCA and the VNS, its largest contractor, and make the argument that these are both innovative actors in the market, whose innovations are not necessarily entirely compatible. Using these descriptions of the operations of the market, I will then return to the concepts outlined in this chapter, seek to apply them to this case, and make some recommendations and conclusions.

Chapter 3 The Home Care Market in New York City

A New and Growing Market

The home care industry is relatively new, and has evolved into its current structure in response to a variety of pressures.[10] Nationally, a major impetus expanding home care was the passage of Medicare in 1965, which increased the number of insured elderly people, and the passage of additional Medicare benefits for home care in 1975. In the early 1980s, home care expanded yet more due to changes in the structure of hospital reimbursement by insurance companies. Rather than paying per diem, insurance companies reimbursed by the procedure. Setting a flat reimbursement rate created a market incentive to reduce hospital stays; every case that could be sent home early would make money for the hospital, and also balance the risk on cases with complications and longer stays. The result of this payment policy, intended or unintended, was that more patients went home needing nursing care, which was provided through benefits for home care. In New York State, a major scandal about nursing homes resulted in strict limits on nursing home licensing and political pressure to favor home care funding at the state level as well.

Another trend that caused home care requirements to increase was demographic; the elderly population has been increasing, and at the same time the number of women in the workforce has risen dramatically. Caring for the elderly, especially those who were frail or ill, became increasingly a social service instead of a family task.

In the 1980s, however, the New York home care market experienced a shake-

[10] This sketch of the history of the home care market from interview, Schulmerich, Montefiore Home Health Agency, and interview, Surpin, CHCA, March 3.

down after its initial expansion; in the face of rapidly increasing costs for home care, reimbursements by Medicare were cut back drastically. Policy changes required training family members, if available, to provide the necessary home care. Eligibility guidelines were tightened so that a significant number of cases were refused, even after care was given; receivables dragged out for months and paperwork requirements got worse. The policy changes caught many agencies unaware; they ran out of working capital or experienced significant losses from lack of reimbursement. Many went out of business, and those that survived restricted the cases they would take to those that were deemed least risky in terms of reimbursement. This trend was halted abruptly by a successful lawsuit against the government challenging the new guidelines. With a finding against the government, new reimbursement policies returned the home care market to a more robust condition, though fewer agencies were left in competition. The Director of Vendor Administration at the VNS reported that between 1986 and 1994, their volume of home care aides' hours more than tripled from about 12 million hours per year to about 40 million. In 1993, market research by CHCA showed the home care market to be increasing at about 10% per year; CHCA experienced about 15% per year growth, and the VNS reported about 20% growth.

Current Configuration of the New York City Home Care Market

The home care market in New York City currently has three sub-markets based on different types of contractors (nursing agencies)[11] organizing the market according to different affiliations and incentives. These types of contractors are independent non-profit nursing agencies, hospital affiliated agencies, and the Human Resources Administration of the City government. The first two groups are each dominated by institutions with a long local history; the Visiting Nurse Service of New York, an independent non-profit agency founded in 1893, and the Montefiore Home Health Agency, created in 1947 as a division of Montefiore Medical Center, the largest hospital in the Bronx.

Independent Non-profit Nursing Agencies

Among the several independent nursing agencies, the Visiting Nurse Service (VNS) is by far the largest.[12] They are one of the long-established social service institutions of New York. Featured in their lobby is an old photograph of a nurse clad in a full-skirted walking suit, black bag in hand, stepping determinedly from one roof to the next on a tenement building, presumably to get to her next patient without going down all the stairs. For most of its history, the Visiting Nurse Service was largely an agency of professionals--nurses and social workers who visited the poor residents of New York.

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[11] Throughout this thesis, I will refer to the paraprofessional agencies as subcontractors, and the nursing agencies as contractors. Within the industry, the subcontractors are generally called vendors, or licensed agencies, and the contractors are referred to as CHHA's (Certified Home Health Agencies.)

[12] The Dominican Sisters are another such independent agency. Information on the VNS was gathered from their 1991 Annual Report and from interview, Lowther-Mandel, VNS.

When the modern home health care market began to emerge in the 1970s, the agency went through a period of hiring its own home health aides. As the market took shape in the 1980s with an increase in volume and then a squeeze on reimbursements, the VNS laid off its aides, and went to a subcontracting system; they continued to provide nursing supervision for cases, but hired aides through separate agencies, at considerably lower cost.[13] Ten years ago, the VNS also established its own paraprofessional agency as a wholly owned, for-profit subsidiary that is the single largest paraprofessional agency in New York, and takes about 25% of the VNS's cases.[14] This subsidiary allow VNS to take advantage of the current structure of the market by realizing profits from the work for paraprofessionals that they now subcontract.

Hospital-Affiliated Nursing Agencies

The Montefiore Home Health Agency also antedates the modern home care market. Established in 1947, the nation's first hospital-affiliated home care agency's original purpose was to free up beds in the Montefiore Medical Center, a chronic care facility with a long waiting list. The hospital's administration thought that patients with more acute types of chronic illnesses, specifically heart disease, cancer and tuberculosis, might be cared for at home, allowing people who were more incapacitated to get the hospital beds. The experiment was successful; not only were beds freed up, but those people who were cared for at home generally did better. This agency became a model for other hospitals over the years, but remains the largest as

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[13] Interview, Lowther-Mandel, VNS.

[14] This agency, Partners in Care, will be discussed further below.

well as the oldest of the hospital-affiliated agencies in the market.

The hospital agencies use the same subcontracting relationships as the VNS; they provide nursing supervision of cases and subcontract from the same pool of home health aide agencies. The major difference in structure and incentives between the independent and hospital-affiliated agencies is that the latter support the overhead of larger institutions. In the past, they received a higher reimbursement rate to help cover overhead costs; after 1992, Medicaid rates were equalized for both types of agencies. However, Montefiore Home Health Agency continues to provide significant revenues to the hospital for overhead and capital expenses. The Executive Director of Montefiore informed me that though her department represented only 5% of the Center's total budget, it contributed more to the bottom line than any other division. Montefiore was also one of the lowest paying contractors among the dozen that CHCA works with, so that the difference in their contribution to hospital revenues is made by reducing the ability of aide agencies to pay wages and benefits.

Human Resources Administration, City of New York

In addition to the two sub-markets anchored by private institutions, the City's Human Resource Administration (HRA) oversees the provision of Medicaid-covered home care benefits.[15] HRA divides home care services into those that can be delivered by less-trained personnel (housekeeping, basic personal care such as bathing) and those that require more nursing supervision and home health aides who have been trained in some health care procedures, such as monitoring vital signs, changing non-sterile dressings and supervising ambulation. HRA directly supervises the basic home

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[15] Information on HRA from interview, John Engel, HRA and Surpin and Dawson (1993).

care services (housekeeping, etc.) and contracts out the more skilled work to the independent and hospital-affiliated nursing agencies. Cases that require home health aide services are generally referred directly to the nursing agencies by hospital or nursing home discharge planners, with approval from HRA to bill Medicaid directly. Cases judged to need only basic services are managed by in-house nurses and medical social workers, subcontracting the paraprofessional care services to independent, generally non-profit, agencies. The HRA system does not compete directly with the other two sub-markets. The paraprofessionals serving this part of the market are less trained, and generally work for different subcontractors than the home health aides who work for such agencies as CHCA. Another key difference between the markets is that the personal care attendants for the City system are unionized, and hold a contract directly with the City to which the subcontracting agencies conform.

HRA sets rates for reimbursement of its subcontractors by negotiating and auditing overhead expenses, and also directly covers several key overhead expenses for its subcontractors, including insurances, training and financing of receivables (Surpin and Dawson 1993, 29). Thus, the discretion of these agencies to respond to market incentives is very limited; their wages and benefits levels are set by the union contract, and their overhead is set by direct negotiation. They function as closely regulated non-profits.

This thesis focuses largely on the independent and hospital-affiliated agencies and their subcontractors, as this is the more market-oriented part of the system. The City sub-market provides a model for government regulation and supervision whose performance could be compared more extensively with the private market, given more research.

Licensed Paraprofessional Agencies - The Subcontractors

Two of the three sub-markets described above subcontract to the same group of licensed paraprofessional agencies, including CHCA. The licensed agencies hire and train their own aides, are responsible for their own overhead and profit margins and set their own wage and benefit scales. Most of these subcontractors hire only semi-skilled labor while the skilled labor (nurses) remains with the contractors. These agencies are generally for-profit firms, of varying sizes ranging from small to over 1,000 aides. They can be roughly divided into three types; branches of large national corporations (generally temporary help firms), locally owned and managed large firms, and smaller specialized firms that serve a particular geographical area or provide aides who speak other languages.

Some of these subcontracting agencies developed the labor practices of low wages, no benefits, and part-time hours that made home care more economical and lower quality in the 1980s. While Union 1199 successfully unionized the personal care attendants that work for the city and improved their working conditions, they have been unable to take on the larger home health aide group. Unionizing the city-paid workers did have an effect on labor practices however. One interviewee commented to me that the threat of an organizing drive by 1199 caused subcontractors to upgrade their salaries and benefits somewhat.[16] Raising wages, however, requires higher reimbursement, and/or economizing on overhead and profit.

In addition, to match the gains realized by unionized attendants in the City system a city-wide coalition spearheaded by CHCA, the New York City Home Care

[16] The Executive Director of Montefiore Home Health Agency.

Working Group, successfully lobbied the state legislature in 1988-89 for an increase in Medicaid rates that was initially required to be passed through to aides. After only a year, however, the labor adjustment was rolled into the reimbursement rate paid to the nursing agencies, with no further requirements on how it would be allocated. With discretion on how to use the higher reimbursement rates, some independent nursing agencies raised their subcontractor rates, while many of the hospital-affiliated agencies held their rates steady (Montefiore actually reduced theirs.) VNS, the largest contracting agency, generally pays the highest rates, though their volume could allow them to bargain for lower ones; the hospital-affiliated agencies generally pay somewhat less; and smaller agencies with less volume tend to pay less, by CHCA's observations. Within the rates that are paid, the subcontractors are free to pay what they choose within the constraints of the market. CHCA pays the highest rates in the city, and keeps its overhead and profit to about 20% of total revenues; the Executive Director of Montefiore asserted that subcontractors generally gross 30-40% over wages and benefits.

A Discussion of the Home Care Market Structure

Several points about the home care market structure in New York City emerge for discussion:

1) One consistent aspect of the market is the subcontracting of the semi-skilled paraprofessionals into a separate layer of firms in all three sub-markets. This contrasts with the organization of hospitals or nursing homes, but is similar to other markets that out-source low-skilled work, ranging from cleaning work to data processing. Why has this organization of the market emerged?

2) Subcontractors can be broadly described as big-volume, national companies, medium to big New York-based companies and smaller, local companies. How do these subcontractors differ from each other, and will these differences persist?

3) The contractors (excluding the City in this discussion) have two different forms, independent non-profit and hospital-affiliated. These agencies, created originally for related but different purposes, now shape the market in different ways. How should we regard these differences? Should government choose one or the other as preferable or continue to let the market work out its own structure?

4) This market is largely shaped by the government; complex interactions of the three levels of government (federal, state and local) involved in funding, regulating and providing care create complications that affect the private market. How has policy shaped the current market structure, especially with regard to the issues of providing good care and decent jobs?

1) Why do the home health aides work for specialized paraprofessional agencies, rather than as staff within the nursing agencies?

Three issues emerge from this question: cost, control, and quality of care. Cost is the most significant, according to my interviews. Both subcontractors and contractors pointed out that this system created low-wage jobs with no benefits, and generally part-time hours. The part-time hours are a further convenience to the contractors, because scheduling a large number of partial-day cases is extremely complex, making it difficult to guarantee full-time hours. The Director of Vendor Administration at the VNS expressed the cost issue very clearly; the VNS lost money on their own aides. Within the VNS the wage and benefit scale was built around a professional staff of nurses and social workers. Aides benefited from this and made as much as $20-25,000 salary per year plus benefits, compared to aides in outside agencies who were making minimum wage. A further cost was the difficulty of laying off workers during downturns as the market went up and down in the 1970s and 1980s. It was clearly to the advantage of the VNS to subcontract the aides' work; the subcontracting structure created a contingent workforce that absorbed the risk of market cycles and whose powerlessness in the system left such a policy unchallenged

(except by the successful unionizing drive in the public sector).[17]

The VNS's strategy of establishing a for-profit subsidiary to compete with other paraprofessional agencies allows them to benefit doubly from this system; not only are the aides maintained in a separate wage category, but the VNS can appropriate the profits generated by their subsidiary to support their overall budget.[18]

Control issues also enter into the separation of aides from nursing agencies. Control refers here to managing the aides as a laborforce. Both the VNS and Montefiore managers referred to difficulties they perceived in increasing the size of their agencies several times over if the aides were in-house. Though they were not specific about these difficulties, I had the impression that the administrative job of supervising so many more people and directly handling all the issues tied into the aides' work would increase their own responsibilities substantially. By contracting out this large and more transient group of workers, they can keep their own staff under closer supervision and require the paraprofessional agency management to deal with a range of issues before they reach the contractor.

In addition, though this was not raised by the contractors themselves, there is a separation between nurses and aides based on professional status that seems to be more accentuated in the medical profession than in, for instance, manufacturing, where semi-skilled workers are often supervised by people who have worked their way up.

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[17] While VNS followed this particular path from in-house aides to subcontracting, I assume that similar dynamics played out for some other agencies. I did not find out when and how the first subcontracting firms got started, and how they entered into relationships with different types of contractors.

[18] These revenues are assigned first to supporting the free care that VNS provides, per the Vice President of Partners in Care, the VNS subsidiary.

Staff at CHCA commented on this separation, observing that one reason they have been reluctant to consider expanding their agency to include nurses is the difficulty of dealing with the great difference in status and expectations between the two groups of workers.[19]

Control is a two-edged sword, however. While subcontracting aides allows the contractors to hold a small number of managers accountable instead of a large number of employees, they also lose some control over supervision and standards. This comes to light when we look at the issue of quality.

The Director of Vendor Administration at VNS made an interesting observation to me. Describing their strategic decisions, she noted that they had become painfully aware that while aides were generating two thirds of their revenue, they were also generating the most complaints about quality of care. This issue posed a dilemma for the VNS, who take pride in their mission of providing good care to the poorer residents of the city (nor should we ignore the potential liabilities this situation created for the largest contractor in the city).

Though government funds pay for much home care through Medicare and Medicaid, government regulations only control quality of care at a very basic level. They require that aides receive a minimum of two weeks of training for certification, and a specified amount of in-service training yearly. Aides must have a physical examination when they are hired and must stay up-to-date on medical tests and vaccinations. Employers are required to run a background check with former employers or other references. These regulations set a minimum standard of

[19] One CHCA staffperson stated that while many nurses work well with aides, some won't even address them directly.

competence and protection of the patients from infectious disease. Contractors are responsible for enforcing these regulations, and conduct yearly audits of sbucontractors' personnel files.[20]

Beyond the basic regulation requirements, the quality of care is defined and managed by the contractors. It was my impression from my interviews that until the recent installation of a significant new rating system by the VNS quality of care has been subjectively measured largely by the number of complaints or commendations received from patients and nurses. Both Montefiore and the VNS chose to work with CHCA on the basis of their promise of higher quality; both have struggled with and let go larger subcontractors who have not satisfied them. The staff people who seem to be most in touch with the quality issue have been the nurses and coordinators, who work directly with the patients and the subcontractors to place the aides on each case. (Coordinators' contact with cases and with aides is almost entirely by phone.) Feedback from these staff has informed management's understanding of who is providing good care and who is not.

Until recently, however, little had been done on the question of _why_ good or bad care was provided. While it seemed obvious to the founders of CHCA that low wages, no benefits, and part-time hours would make workers less likely to provide quality care, the structure of the market did not bring attention to bear on these issues. Aides typically signed up with a company (after receiving their certification) and waited for a phone call to place them on a case. Frequently, they would end up

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[20] The Quality Assurance Department of the VNS is in charge of these audits, though not the new quality rating system for subcontractors, pointing out the difference between the traditional view of quality control and a new, more assertive policy of subcontractor management.

putting their name on the list with several companies, in order to get more work. This also led to their shifting between cases depending on the calls they got - not a good system for setting up consistent care for patients. Aides were not attached to companies (many had contact with companies only by phone and mail) and their incentives to provide quality care were minimal. Those who did presumably did so out of basic human kindness. Though the internal practices of subcontractors may have caused problems to the nursing agencies, it appears that they did not get involved in intra-firm issues.

Later, I will explore further the issue of how the quality of care given relates to structure of the market. I will particularly be focusing on CHCA's strategy as a firm, which links quality jobs with quality care, and the VNS's new subcontractor rating system, which has allows them to use some more objective criteria for judging the quality of subcontractors'.

2) How do subcontractors differ from one another, and will these differences persist?

As described above, there are essentially three types of subcontractor companies serving the majority of the market for the hospital-affiliated and independent nursing agencies. These are branch offices of large national firms, large New York-based firms, and smaller local agencies (of whom CHCA with about 300 aides is one.)[21] First I will sketch out how these different types function in the market, and then discuss what I learned of their performance from my interviews.

[21] I believe that there are also a number of small agencies, referred to by one contact as "Mom and Pop" agencies; I am focusing largely on the subcontractors who serve the VNS and Montefiore, two larger contractors.

The national companies are able to handle a large volume of cases; their deeper pockets allow them to set up large offices and handle larger receivables. (Working capital is a concern in this industry because of slow reimbursement processes.) Particularly as the market grew at such a rate in the late 1980s and early 1990s, this ability to provide a large number of aides is important. Large agencies also benefit from economies of scale. Rick Surpin of CHCA told me that their own calculations for financial forecasting bear out the assumption that in service organizations average overhead costs tend to go down as scale goes up. As size increases, profits increase until you cross a threshold requiring new investment in space or in another layer of management personnel.

Branch offices for national companies, however, support a corporate overhead as well as their own, and many are accountable to shareholders as well. I inferred, however, that these firms do not generally provide better quality of service; the VNS's Director of Vendor Administration stated that all her better subcontractors were New York-based firms.[22] This suggests that their response to market incentives and their accountability to corporate goals does not lead to good practices in providing care.

Large New-York based companies were highly spoken of by the Director of Vendor Administration at VNS. These companies generally have an owner-manager, whom she can hold more personally accountable, and support only their own overhead. They are large enough to take a substantial portion of the caseload, with some corresponding efficiencies for the VNS, but are not responsible to a national

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[22] It was reported to me by staff at CHCA that VNS dropped contracts with two national companies over quality issues, and that Montefiore had dropped such a company in the 1980s, when CHCA was just getting started.

company. Their profits presumably go directly to their local owner-manager. One or two of these companies were referred to by several different people I interviewed as companies that they called to get advice on how to solve problems or improve practices, whether subcontractor or contractor.

CHCA fits into the third category of subcontractors, smaller New York companies. These companies generally serve niches, according to the VNS; their smaller size can be an inconvenience for such a large organization, but their specialties are worth it. The niches that were identified to me included language (i.e., Chinese-speaking aides), geographic area (i.e., the Bronx) and community base. VNS maintains contracts with a small number of community-based non-profit agencies, according to the Director of Vendor Administration, because of their community connection and longstanding relationships these particular agencies have with the VNS.

CHCA has a unique reputation; its quality of care is mentioned by everyone, and managers from other agencies call CHCA for information on "best practices" in order to improve their own performance.[23] The VNS Director of Vendor Administration specifically mentioned that although its size was small, it is a valuable resource to her. Besides its practices and its quality of care, CHCA serves a difficult neighborhood in the city, the South Bronx, and with one or two other firms has priority for cases in that neighborhood.

From this discussion we can conclude that subcontractors provide different services to the large contractors, which can be summarized as volume, quality,

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[23] This was mentioned to me by both the Director of Vendor Management in the VNS and the Vice President of Partners in Care, the VNS subsidiary that is a competitor of CHCA's.

accountability, and specialties. Few firms seem to provide all these at once, although a few of the New York-based firms may come close.[24] I asked the Director of Vendor Administration at VNS why they dealt with so many subcontractors (twenty-five). After commenting on how she valued different subcontractors for their quality or specialty services or volume, she went on to say that the VNS had considered a joint venture strategy, combining forces with a large national corporation to run a single operation providing most of their home health aides. Her objection to this scheme was that she feared that she would be unable to control the quality of care, that the two organizations would be too entwined for her to insist on changes in policies concerning quality. In the current structure she works with a number of firms that she has virtually made by giving them so much business; these firms (obviously more likely to be the New York owned ones) owe her favors in return, and she can draw on their manager-owners for problem-solving and advice.

One reason for doubt about the success of a relationship with a large partner may be VNS's experience with its own subsidiary, Partners-in-Care, which already handles 25% of its caseload. When I asked Partners' Vice President how they had fared in VNS's new rating system, she said that they had not done too well at first. Interestingly, she had called around to competitors like CHCA and Progressive Home Care, and had isolated one significant practice that seemed to account for their different performance; Partners-in-Care had a 38% lower ratio of supervisors to aides than these other companies with higher performance ratings. This ratio reflected the

[24] Progressive Home Care, which has 1200 aides, was mentioned in several interviews as a quality leader and a source of information about best practices; they are fairly large, locally owned and more accountable, and serve the Bronx as well as other neighborhoods.

cost-cutting policies stressed to Partners by the VNS, whose motivation is to keep costs down and increase the profits realized by their subsidiary. Partners has now hired a number of additional supervisors and recently moved to larger quarters to accomodate more office-based staff. This example shows the two-edged sword of close relationships that the Director seems to be wary of; because the two agencies are mutually dependent, the more powerful one can constrain the other to strategies that turn out to be unproductive in some ways, while the less powerful one needs some kind of outside leverage (i.e., the "objective" information from the rating system) to change policies. These relationship issues may be quite similar in the hospital sector, where the home care agencies are supporting the larger agenda, and budget, of a complex institution.

A last comment on reasons for the diversity and number of subcontractors; the Director of Vendor Administration needs a large group of subcontractors because her market has been growing almost 20% a year for the last few years; even the large number of subcontractors can barely keep up, and she is considering whether to put out a Request for Proposals next year to get additional subcontractors onto her roster. Partners-in-Care has been unable to keep up with the demand, and their share of the VNS caseload has fallen from 30% to 25%, though their actual volume has increased.

Will these different types of subcontractors persist in the market? Much depends on what the contractors do. A few years ago, Montefiore Home Health Agency cut the number of subcontractors it dealt with from thirty-two to twelve, required a discount for volume, and held their reimbursement rate steady for three years until it was one of the lowest in the city. This re-shaped its demand considerably. If VNS were to make similar decisions, or to go with the joint venture company it has

considered, the subcontracting market would change more drastically. The three subcontractors with whom I spoke are all about ten years old, possibly indicating that a certain structure emerged in the market around that time that has consolidated itself. If, however, this structure were to change either because of policy changes such as health care reforms or reimbursement rates, or because of the strategies of the contractors, the types and sizes of successful subcontractors might change considerably. Below, I will propose some changes that might be made in subcontracting relationships; these changes presuppose a similar market structure with a number of competing subcontractors, but a stronger set of rewards for quality. Subcontractors who could not respond to new incentives and constraints would leave the market, while others could expand.

3) How do the differences between contractors in this market define the market structure?

The contractors in this market compete with each other in some areas. The hospital-affiliated agencies generally serve their own hospital's patients, and may refer some to the VNS. The Executive Director of Montefiore stated that she would refer patients from her hospital to other hospital-affiliated agencies, particularly within the hospital alliance to which Montefiore belongs, rather than the VNS. She ascribed this to problems with both the quality and size of VNS, and to better trusting her ability to resolve problems with other hospital administrators whom she knew. The VNS, on the other hand, has clearly succeeded in marketing its services well enough to dominate the market in terms of sheer size. It handles patients from many hospitals that do not have their own home health agencies, in addition to any patients that the

hospital agencies do not want to carry.[25]

VNS has grown at a tremendous rate in response to the changing home care market; the value of contracts for home health paraprofessionals with outside agencies has grown to about $200 million, almost two thirds of the VNS' entire budget.[26] The VNS subcontracts about 15 times as many hours as Montefiore Home Health Agency, the largest of the hospital-based agencies. The VNS considers itself obligated to take any case that is referred to it, and provides free care in the amount of about 2% of its budget.

This growth has not been without difficulties; the VNS was nearly bankrupt in the mid-1980s as it struggled internally to learn to manage a whole aspect of the business that was quite different from its nursing and social service functions, and externally to deal with the shifting policies on reimbursement. A new emphasis on the details of business resulted from its financial crisis, and the current Director of Vendor Administration came in with a mandate to restore this department to fiscal solvency. She was one of the first administrators at a high level who did not have a nursing background, a trend confirmed with the appointment four years ago of a new President and Chief Executive Officer whose background was in policy and management.

By focusing strongly on its internal organization and ensuring that the necessary paperwork from subcontractors was obtained and processed for reimbursement, the VNS was able to restore its financial position to the point where it now has substantial

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[25] Subcontractors described hospital agencies as choosing the "best" patients, those with private insurance, long-term needs, good neighborhoods or other desirable qualities, and referring the others to the VNS.

[26] Interview, Lowther-Mandel, April 1.

surpluses each year. With the financial situation under control, the VNS has turned its attention to quality issues, a top concern of their President. Concerns with both fiscal management and quality control of its subcontractors' work resulted in a substantial investment in a mainframe Order Processing System (OPS) that tracks a level of detail and generates reports of a kind impossible to do by hand with its volume. Both its profitability (in non-profit terms) and size have made Vendor Administration a key part of the organization; it also controls the majority of actual hours of care given to VNS patients and therefore is key to the drive for higher quality care.

VNS falls somewhere between government bureaucracies and firms in the market; its size and its mission as a social service agency rather than a stockholder-owned for-profit company make it function more like government offices of similar size. On the other hand, it has been chastened by the market as well; its brush with bankruptcy has led to a focus on efficiency that would be considered exemplary in many government offices, and leads it to manage itself more like a business. Its new President's priority on quality also brings in the world of the market; she insists that customer satisfaction become the root of their policies and procedures. Few bureaucracies or market firms attempt to serve the poorest residents of New York with such a creed.

Mixed incentives and motivations can be seen in the VNS's relationship with Partners-in-Care, its for-profit subsidiary. As mentioned above, VNS's control over issues of cost and quality seemed to be greatest in its relationships with independent subcontractors. By holding them accountable to certain standards, but leaving them to design their own internal practices, VNS fostered the development of some practices in the subcontracting system that even their own subsidiary benefited from.

As Partners-in-Care and the VNS experience tensions around cost and quality issues between them, the hospital-based agencies take these issues up another level in the system. These contractors are responding to the same pressures as the VNS subsidiary; they must contribute to the overhead of their parent institution. One place that these pressures clearly play out is in the rates paid to subcontractors. From CHCA's rates of payment from different contractors, it is clear that the VNS and the Dominican Sisters (another independent non-profit contractor) pay at the top end of the scale ($11.85 to $12.24 per hour depending on the type of case), while Montefiore and a number of the other hospital-based agencies pay at the bottom ($10.16 to $10.65). The 15% increase in the rates being paid by the independents represents substantial potential profit, but also a substantial difference in the wages and benefits that can be paid.[27]

In this area, the strategies (low price vs. high wage) of the Montefiore agency and of CHCA come into direct conflict. The motivations of the market structure lead to skimming off a higher level of profit at the contractor level in order to support a larger institution, while the next tier down (the subcontractor market) is squeezed. When Montefiore does business with a large firm and requires a volume discount from them, the structure of overhead costs and profit incentives requires that the subcontractor run as large a volume as possible and minimize their wage payments and overhead in order to make a profit. It should also be noted in connection with the Montefiore rate structure that hospital agencies were until recently paid a higher reimbursement rate than the independent contractors in recognition of the fact that they

[27] This difference could go more to wages and benefits if quality is made a criterion of getting these better contracts.

bore a share of overhead costs for the institution. From this higher rate of reimbursement and a lower subcontractor rate, Montefiore found it easier to make profits as its Director described.

While everyone in the industry talks about quality of care and commitment to patients, the ways in which the contractors are organized differ significantly and generate different results for subcontractors, aides and presumably patients as well. Non-profits' position in the industry is important, because they can combine social goals with business-like competitiveness.

4) How has policy shaped the current market structure, especially with regard to the issues of providing good care and decent jobs?

My research touched the role of government policy only in a peripheral way, but led me to a few important observations. One is that the involvement of three levels of government in the budgeting, regulating, rate-setting and operations of the market generates confusion and duplication. Payment for home health care, which is most used by the elderly, comes from three sources:

- Medicare (universal health insurance for the elderly, covering acute care),
- Medicaid (health insurance for people below the poverty line, provided to AFDC recipients and covering chronic care for the elderly),
- private insurers.

Each of these systems has different rules concerning qualifications, hours of care to be provided, and so on. For instance, elderly poor patients receiving chronic (long-term) care through Medicaid may enter the hospital for acute illnesses. During their recovery at home, they would receive care through Medicare; after that recovery period, however, they would return to Medicaid and the chronic care rules for services.

Practically speaking, these shifts in coverage may mean switching aides several times[28]. Staff at both the VNS and CHCA commented on the confusion many patients have about who is providing service; between changes in coverage, two different agencies providing nursing supervision and home health aides, and potentially separate services from the City program as well, patients may see several different faces in a day and not understand who works for whom.

In addition to the confusion for those providing and receiving services, a case can probably be made that bringing benefits available to patients into a single consistent system would economize on both government administrative costs and the market costs involved in scheduling and billing with different programs.

With regard to quality of care, the government, as discussed above, has set a basic standard for training and health of aides, but the significant level of quality management and standard-setting is in the hands of the contractors. In terms of quality of jobs, the city government now works with a union that sets working conditions through its contract; at the state level, however, the only requirement on wages made was the temporary pass-through rate increase for home health aides that was negotiated after the union contract for home care attendants was signed (though the home health aides remained non-union). Within two years, however, this pass-through was folded into the reimbursement rate for the contractors, with no requirement that it be passed on to aides as wages. The only voice aides have at the state level is through progressive subcontractors' or contractors' associations that raise working conditions issues in their lobbying campaigns.

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[28] Surpin and Dawson 1993.

Summary

Throughout this description of the home care market in New York City, I have discusse how aspects of the market structure affect quality of care and quality of jobs. The complexities of the subcontracting structure of the home care market play out in two ways. There are advantages and disadvantages of keeping aides outside the nursing agencies; it allows subcontractors (if they choose to) to focus on the best practices for dealing with the laborforce that provides the bulk of the care, but also allows nursing agencies to be blind to the fact that the market has created contingent work conditions of the worst kind for aides. The place where this comes home to roost is in the quality of care provided; given the informal nature of quality monitoring (until the recent system established by the VNS and discussed in detail below) contractors seem to have had little handle on the roots of quality problems, and sometimes little ability to make substantial changes. From the point of view of both subcontractors and contractors in the system, then, there has been difficulty in relating the quality of care to the quality of work for the aides.

The contractors in the market provide two significant models, independent non-profit nursing agencies and hospital-affiliated agencies. I have raised the question of whether the affiliated agencies respond to the issues of quality of care and quality of working conditions for aides as effectively as the non-profits, particularly the VNS, which due to its size can marshal significant resources in response to social mission priorities.

The dilemma of this market is that it provides a public good in two significant ways; it provides home care to poor and elderly patients through substantial outlays of government funds (though presumably less than would be paid to support these people

in nursing homes), and in New York City it provides jobs that are accessible to women who are at the bottom of the labor market in terms of skills and education. Yet there is no institution in the government that is set up to consider the relationship between the effects of government expenditures in the private home care market and the employment results created by that market's structure.

Having examined several key features of the structure of this market, I will now turn to a more detailed look at the relationship between one contractor and subcontractor, the VNS and CHCA. This relationship between two progressive agencies in the market has tensions and contradictions as well as the potential to elucidate challenges and opportunities in shaping this market to serve its public purposes better.

Chapter 4 Cooperative Home Care Associates and the Visiting Nurse Service of New York

Cooperative Home Care Associates and the Visiting Nurse Service of New York both play distinctive roles in the home care market in New York City, though they are very different organizations. In the relationship between these two agencies, CHCA is a small but respected subcontractor and the VNS is the largest contractor in the city (by far) paying one of the highest rate scales for subcontractors. More important, both these organizations explicitly take on the issue of quality. CHCA's strategy is built around creating better jobs for home health aides, and the Visiting Nurse Service's organizational priority is to "put the patient first"--to improve the quality of home care service.

To describe their relationship, I will discuss their separate organizational goals, their needs relative to each other, and the specific ways in which they have direct contact with each other. Understanding these aspects of this specific relationship will also contribute to a more detailed understanding of how subcontracting relationships in this market work.

I will then describe the new subcontractor rating system that the VNS has developed, which mediates the VNS' relationship with all its subcontractors by defining quality with new, more formal criteria. This system changes the character of subcontracting relationships with the VNS, and potentially lays the basis for yet more innovative changes. Initially, it has shifted costs to subcontractors and increased demands on them; however, it has also brought more attention to bear on how the

practices of subcontractors affect their performance. In this respect CHCA, whose practices as an employer are exemplary, has much to offer.

In the following chapter, I will draw on this example of a subcontracting relationship to outline current practices, discuss how the structure of this market does and does not further the aims of quality of care and quality of jobs, and how innovations and new practices in subcontracting relationships might change the market's effectiveness in meeting public purposes.

Organizational Goals

CHCA's goals, simply put, are to provide quality care and quality jobs. They are more fully described in "Cooperative Home Care Associates: History and Lessons" as:

- **enterprise development**
  "Enterprise development is a strategy of spawning businesses not simply to maximize profit, but to create decent jobs or provide needed services in underdeveloped areas."

- **a democratic firm**
  They are now the "largest democratic start-up in the United States."

- **innovation laboratory**
  Their "outsider perspective and emphasis on quality [creates] a high degree of experimentation in both management and training practices."

- **yardstick corporation**
  They propose to provide standard by which to judge other companies in the market, to be "a private company whose accomplishments are respected and whose analysis is trusted by public regulatory agencies, health policy organizations, labor organizations and the media."[29]

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[29] "Cooperative Home Care Associates: History and Lessons," prepared for the Home Care Associates Training Institute by Steven L. Dawson and Sherman L. Kreiner, January, 1993.

The VNS's goal, as expressed in its 1991 Annual Report, is to provide "innovative leadership in responding to the health care needs of New York's diverse population," as the "largest nonprofit home care agency in the nation."

> "The Visiting Nurse Service of New York is uniquely positioned as a leader in meeting the health care needs of the New York community; in contributing solutions to the complex problems in our health system, both locally and nationally; and in providing access to health care for our neediest patients."[30]

As an example of its commitment to social missions, in 1991, out of total operating revenues of $277 million, the VNS provided $12 million of free care (over 4%).

Organizational Needs

From my own observations and interviews, I have developed a list of what each of these agencies needs from the other--the operational side of goals. CHCA requires from its contractors:

- the highest possible hourly rate from contractors, to pay their high (for the industry) wages and benefits;
- flexibility in the scheduling of cases in order to offer full-time work to most of their aides;
- low overhead costs, in order to maximize both wages and dividends for worker-owners.

The VNS requires from its subcontractors:

- efficiency in handling the vast amount of detailed data requirements for tracking cases and service, complying with regulations and producing documentation for reimbursements;
- reliability and quality in the care provided by home health aides;

[30] Excerpt from "Message from the Chief Executive Officer," 1991 Annual Report of the Visiting Nurse Service of New York, p.3

- ability to place difficult cases successfully especially given that no premium rates are allowed[31];
- responsiveness and problem-solving help from subcontractors; and
- ability to help VNS meet the current growth in demand of the market, which is about 20% per year.

Compatibilities and Incompatibilities of Organizational Needs

Both organizations see themselves as having a social mission; both also function in the private market, struggled to survive financially in the 1980s, and understand the importance of the business side of social mission. To put their strategy differences very simply, the VNS seeks to provide good care (and may find that good jobs are a necessary part of that strategy) while CHCA seeks to provide quality work and incorporates quality care as a means toward that end.

The VNS's high subcontractor rates are vital to the high wage strategy of CHCA, but neither flexibility in scheduling nor low overhead costs for subcontractors (CHCA's other two needs) are issues that the VNS addresses directly. And while CHCA is strong on quality and efficiency and has been a resource to the VNS on questions of good practices, it is not willing to pursue a growth strategy that increases its staff by more than about 40 aides per year (limited by its training program). This means that CHCA is unable to respond strongly to VNS's growing demand. (CHCA decided not to open another office in New York, duplicating its overhead and diffusing its efforts, though it has spun off a separate Training Institute to oversee independent companies replicating its model in other cities.)

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[31] "Difficult" refers to factors like inaccessibility by public transportation, patients who don't speak English, etc., and to patients and families who are personally difficult.

A more subtle incompatibility can be identified around the way that CHCA champions the cause of its aides and its unique way of doing business. In its relations with the VNS, it seeks to protect those internal aspects of its strategy that it sees as crucial to its employment goals; to the VNS, the concerns that it raises can seem peripheral. While CHCA is well-respected, I noted that the Director of Vendor Administration referred to CHCA as a firm that had its own agenda, seeming in her discussion to separate it from those firms with whom she had her closest relations and on whom she could depend the most for meeting her requirements.

While the goals and requirements describe the outlines of the relationship between CHCA and the VNS, an equally important aspect to be concerned with is the actual interactions between staff of the two organizations. This is important in understanding what works well, what does not, and why.

Organizational Interaction

Top level managers at CHCA and the VNS meet, as would be expected, on policy and contract level discussions. The President of CHCA has access to both the Director of Vendor Administration of the VNS and, more rarely, the CEO. At the operations level, the most frequent contact is between the coordinators of the two agencies. Coordinators are responsible for the actual scheduling arrangements, everything that relates to getting aides into patients' homes. Coordinators deal with assignment of aides, lateness or absences, changes in schedules, and so on. These are the individuals who have the most frequent daily contact between the organizations.[32]

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[32] The Manager of Patient Services at CHCA referred to coordinators speaking to each other twenty times a day.

Given the intricacies of scheduling the huge volume of cases, many of which are short-term (35% were under a week in 1991)[33], it is not surprising that these are the people who have the most contact.

Curiously, the actual provision of services creates relatively little contact between staff of the two agencies; nurses visit typical cases every two weeks, while the aide is usually there every day (though their time tapers off unless the case is long-term care). Nurses set up the cases, meet with the aide initially and have some follow-up contact with them, but during most of the time that the aide is in the home, there is no supervision. Nurses certainly can know and value aides and their work; commendations of aides frequently come from nurses as well as from patients. However, given the size of the system and the random effects of scheduling, a particular nurse and aide might easily work together only once, and during that time, their contact would be minimal.

The importance of understanding which level of these organizations has the most contact should not be underestimated. When CHCA was starting up, its understanding with the management of Montefiore Home Health Agency was that it could get more afternoon hours to make full-time work available to aides. This was key to CHCA's strategy of improving working conditions for their employees. However, the extra hours did not materialize; cases assigned to CHCA were largely morning hours. It took some time for CHCA administrators to understand how the system really worked; they had to develop a good relationship between their coordinators and Montefiore coordinators to get afternoon hours scheduled.

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[33] 1991 Annual Report of the Visiting Nurse Service of New York, p.10.

Even now, when CHCA is providing full-time hours to a high percentage of its staff, its Manager of Patient Services (who supervises the coordinators) commented that they are succeeding in getting full-time work by maintaining good relationships with VNS coordinators--politely asking for some afternoon case hours when they've taken several morning cases, and so on. (Long-term cases that require aides seven days a week also help the full-time hours, but they require that an aide work six hours a day for twelve days straight.)[34]

Thus, while negotiations at the top levels of these two organizations might result in ideas for new systems, these systems would not function unless staff at other levels, especially coordinators, are well-informed and trained as necessary.

The VNS Subcontractor Rating System

In 1991, the VNS began a major investment in advanced information systems for both patient management and managing subcontractors. With a mainframe computer and a dedicated software system, their new Order Processing System (OPS) allowed the VNS to have a file entered by its subcontractors on aides before they are assigned to a case to verify that they meet all the requirements of the regulations, to process phoned-in case requests from the nurses and to communicate with subcontractors directly through the computer. In the morning, when CHCA staff come to work they find the day's case assignments on their terminal. Duty sheets (time sheets) are

[34] Though this is not an issue I discussed in my interviews, it seems clear that the coordinators' position is the most likely to invite corruption; coordinators exercise a lot of personal judgment in assigning cases, and have tremendous power over either the subcontractor coordinators, or the aides; in either case the possibility of influencing these decisions with favors or bribes is obvious.

entered into the system directly, and the system tracks discrepancies between hours assigned and hours worked. Invoices are generated from the system as well.

In addition to the managing of scheduling and financial information, the OPS allows VNS staff to maintain records of quality issues. VNS managers put a lot of thought into how to tackle the questions of criteria for defining quality, measurement and monitoring. Extensive discussions with their own staff brought up the most serious issues from the point of view of care and coordination. Patient surveys proved initially to be a more disappointing source of information. It seemed that patients were generally unwilling to raise issues; they apparently feared that comments might make things worse for them, or result in losing an aide to whom they had grown accustomed.

The VNS Guidelines for subcontractors, issued in January, 1993, reflected what the Director of Vendor Administration described as a first pass at the quality monitoring. Problems were termed "service issues"; the categories were:

- Patient did not receive service
- Patient received late service
- Patient received incomplete service
- Patient refused service
- Vendor failed to communicate with VNS within 35 minutes of requested start time of case.

These service issues represented 70% of the overall rating of the subcontractor; the balance of the rating was based on acceptance of difficult cases (10%) and site survey results (20%). "Difficult cases" included live-ins, short hours, AIDS patients, non-English speaking patients, and geographical areas hard to reach by public transportation. "Site survey results" referred to the traditional quality assurance task of auditing personnel records on site at the subcontractors office to verify compliance

with legal requirements for aides' training and medical tests.

The first CHCA "report card" I saw for the 4th quarter of 1992; by the 4th quarter of 1993, the categories of the performance ratings had been revised as follows:

- Service Issues/Incidents
- Borough Satisfaction
- Administrative Efficiency
- Site Survey Results.

"Borough satisfaction" was based on surveys of the nurses and the Patient Service Managers in the borough offices, and "administrative efficiency" covered timeliness and accuracy of entry of various kinds of data into the OPS system. Another category added as a trial run, but not included in the scores for that quarter, was "Reported vs. Not Reported"--the number of service issues reported by the subcontractor themselves versus the ones that came to light from VNS's nurses or from random verification calls.

I asked the Director of Vendor Administration about the results of the rating system from her point of view. She said that the numbers on the ratings apparently look worse now than they did a year ago when they started (for instance, CHCA had slipped from above average to average with their last quarterly report.) This has led some VNS managers to question the effectiveness of the system, but the Director maintains that the slippage is an effect of the increasing reporting level as both VNS staff and subcontractors become more familiar with the system. From her own discussions, she is confident that nurses seeing real improvements in the field, and are pleased with the results of the rating system.

The Director discussed the issue of comparing subcontractor ratings between subcontractors who were more and less diligent on reporting. Obviously,

subcontractors who reported less would look better on the rating system, even if they were caught out on a few incidents by VNS staff. The addition of the "reported vs. not reported" category is an effort to deal with this problem, but will not resolve it completely, as random telephone monitoring may not effectively detect problems. (She characterized CHCA as "compulsive" about reporting, although I did not find out whether she actually mentally revised their ratings accordingly.)

Nor are VNS administrators confident yet that their rating system is internally consistent--that it measures what they are trying to measure. Time has been spent in discussions with subcontractors to clarify and sometimes revise their definitions of service incidents. With the introduction of new ratings getting at more subjective indicators of quality, such as the "borough satisfaction" category, these difficulties are even greater. The first two quarters of borough satisfaction ratings were very inconsistent; the Director suspects that borough staff's reading of the questionnaire varied, and perhaps that questionnaires cannot elicit the information she is seeking. The category attempts to address complaints from VNS staff about lack of responsiveness from subcontractors on problems with aides or with patients. (The director noted that one of the reasons they were moving into these more subjective areas was because the field staff concern about issues such as lateness and absences had been reduced already.)

The reporting and evaluation system has also shifted responsibilities within the VNS in some respects. Before, the nurses were the primary agents for quality issues, backed up by a Quality Assurance department that was also responsible for contract compliance. The Director of Vendor Administration described her coordinators' previous role as liaisons, passing messages back and forth between nurses and case

coordinators in the home health aide agencies. With the new emphasis on customer satisfaction under VNS's new President, Vendor Administration staff were asked to take a more active role in problem-solving. Coordinators now try to handle issues such as coverage before contacting the nurse. This increased responsibility fits in with their new role in the reporting and evaluation system, and their active involvement with subcontractors on the issues of quality. Although I did not pursue the question, I was very curious about the ramifications within the VNS. I did ask how the nurses liked this change in roles; the Director said they apparently are happy with it. How the Quality Assurance Department fits into this new strategy was not clear to me. The discussion did point toward coordinators' key role, as discussed above, expanding further.

Overall, the Director's assessment of the rating system's effectiveness so far is that it has "raised consciousness;" even if subcontractors are not all "above average" yet, they understand the VNS's priorities better, and have responded significantly. In the next section, I will discuss the effects of the rating system from the subcontractors' perspective, leading into further discussion of the potential of the rating system as part of more significant changes in the market.

How does this system change VNS's relationships with its subcontractors?

While the rating system has definitely changed relationships between the VNS and its subcontractors, it is difficult to separate all the aspects of this change. I will review them as I understand them, believing that by understanding how subcontractors have responded to this change we can proceed to ask more comprehensive questions about change in the home care market and how to better achieve public purposes such

as quality care and quality jobs as well as market efficiencies.

To begin with, the OPS and the rating system have put new burdens on subcontractors. The VNS chose to set up its system as a mainframe with terminal connections from the subcontractors' offices. Subcontractors must purchase the terminals, and they are responsible for the data entry, which requires more staff time. For any subcontractors who, like CHCA, already ran their own data systems, the VNS system creates the need to enter data twice because it will not accept information downloaded from any other report. Subcontractors enter data directly into the OPS from their VNS terminals and then must enter this information into their own systems along with their other contractors' data to maintain their own control systems. Processing the reports on service issues and resolving outstanding issues also requires more administrative time than the previous more informal (and less comprehensive) system.

One subcontractor ruefully described the rating system as "the most punishing experience." Another said that while they often felt harassed by the system, they could not disagree with many of its goals, and they had improved some of their internal procedures in their effort to meet VNS requirements better.

I heard about specific changes that had been triggered by the rating system from several sources. One, related above, was the discovery by Partners-in-Care that it was not providing good quality care because it had too few supervisors. CHCA set up a new morning system; one coordinator now comes in at 7:30 to begin handling calls about lateness or absences, in order to be able to report to the VNS within 35 minutes of when their office opens at 8:30. CHCA also designates back-up staff now so it is easier to cover absences.

More subtle reactions come through in reports on the coordinators' grapevine. Coordinators from other subcontractors interviewing for positions at CHCA have provided a window on some practices in dealing with the rating system; one is not reporting service issues,[35] and another is dealing with VNS cases before other contractors' cases. If replacements are only available for two out of four cases, they would go to VNS patients first. While this is fine from the VNS's point of view, it indicates a developing two-tiered system of quality that may be detrimental to the market as a whole, unless and until other contractors try to match the VNS on monitoring quality.

The ratings have generated tensions. Subcontractors characterize the VNS as unnecessarily rigid in its approach. One cited a refusal by VNS staff to adjust a ratio to reflect an actual increased number of case hours which would make the ratio more favorable. Other complaints concern the definitions and procedures around service incidents. Lateness reported early is still considered a service issue, though an absence reported early is not. An absence with no replacement at the request of the patient is not a service issue, while a replacement aide who is unable to arrive on time, even if accepted by the patient, is an issue. Recently VNS apparently threatened to make a service issue out of calls to the OPS help line if they didn't decrease; as a subcontractor said, "It's supposed to be there so you can get help! How can they make that a service issue?" More than one subcontractor commented that it is expensive to do work for the VNS now, because of demands on administrative time

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[35] One story was that because a coordinator forgot to report a no-coverage in 35 minutes (which had been accepted by the patient and would not have been a service issue if reported) they were told by their supervisor to bill the time anyway, to avoid a service incident report.

and extra data entry. This bears directly on CHCA's strategy of paying better wages by keeping down their overhead.

For CHCA, the tensions run deep. The system has added to their overhead and has not helped them on another issue of importance to them, getting more afternoon cases to make full work weeks for aides. The rating system seems to increase VNS's focus on many details of the subcontractors' work. VNS is now adding a service issue concerning how subcontractors introduce their agency to patients; they must say they are "calling from the VNS," instead of using their own firm's name. While this may result from a laudable desire to reduce confusion for the patients, it goes against the letter of the contract which specifically states that subcontractors are not to be considered part of the VNS, and also bothers staff at CHCA who are very proud of their firm, and wish to be known for who they are. Besides the large and small inconveniences of the rating system for CHCA's operations, CHCA feels that it is a one-way street; there are more and more requirements but no substantive rewards for achievements, nor chances to negotiate to get the system to streamline their own operations.

An underlying issue to me was whether CHCA has suffered a little in the rating system. Because of their honesty in reporting (on one report card their self-reporting was 93% of service issues) they may not stack up as well as they should. While their reputation is very strong, and they were regularly mentioned to me by contractors and subcontractors as a source of information on best practices, they were not quite at the top of the VNS's list of best performers. I found myself wondering about the effects of numbers on people's perceptions, even when leadership is sophisticated about what the numbers really mean.

The rating system seems to engender a more active set of requirements of VNS subcontractors--more specifications about more interactions. This promotes the possibility of either improved understanding and communication or of increasingly bureaucratic and regulatory behavior alienating subcontractors and increasing the energy going into cheating the system.

On the positive side there are two developments that indicate that the rating system and the VNS focus on quality may be improving communication and mutual effectiveness. One is a subcontractor advisory committee created by the VNS, which meets regularly to discuss issues of doing business together. This committee was initiated along with the rating system, and serves to allow VNS to introduce new requirements and explain them for the benefit of subcontractors, and allows subcontractors to give feedback about problems they have. The feedback is necessarily inhibited by the power position of the VNS, but the existence of the committee recognizes the importance of communication at least in theory.[36]

Another more significant change is the increased discussion of subcontractor best practices, both among subcontractors and between them and the VNS. The Director of Vendor Administration described what seems to be a new and much more active process of intervention with subcontractors providing poor quality, that seemed to be generated by the ratings. Subcontractors with bad ratings are expected to meet with a staff person from Vendor Administration and work out a plan to improve their ratings. This has led to a conscious effort by the VNS to discover the good practices of high quality subcontractors (by the simple expedient of calling them up and asking them)

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[36] The Director of Vendor Administration commented that she was disappointed in the lack of feedback from subs in this forum.

and to suggest to problem subcontractors that they adopt these practices. One example mentioned was careful selection in hiring. While CHCA interviews each candidate several times before hiring them, and then puts them through an intensive training process, some subcontractors are still following the temporary help model of taking people that walk in the door with the most basic qualifications (the home health aide certification.)

The Vice President of Partners-in-Care commented to me that she feels that there is more cooperation now among the competing subcontractors than even a couple of years ago. She mentioned a recent meeting with four other large subcontractors on the subject of preventing abuse of aides by patients or their families. In the past she would not have expected to call other subcontractors for the kind of information about internal practices that led to her hiring more supervisors. She noted that subcontractors now share more information about job candidates as well. While we don't know how much of this may be due to effects of the rating system (and it is easier to cooperate in a rapidly expanding market when firms don't have a lot to lose) it seems to coincide.

A puzzle to me was the lack of strong rewards or sanctions in the system. When asked what carrots and sticks she had, the Director of Vendor Administration said volume and types of cases. Good subcontractors can count on more volume, and she is eager for them to expand to take it. Poor subcontractors are cut back, whether to serving only certain boroughs of the city or to a limit on hours, until they can demonstrate improved quality.

Good subcontractors can get better cases, ones that are in good locations or have long hours, or may have private duty in addition to the hours covered by insurance,

though Partners-in-Care, the VNS subsidiary, can get first pick. However, the Director made it clear that she also expects her good subcontractors to take the difficult cases, and there is no rate premium. Accepting difficult cases, defined in terms of location, language, short hours and so on, was in the rating system; cases with difficult individuals are time-intensive as well, and she expects these to be handled by her good subcontractors. She commented that since she has provided them with so much business and profit, they owe her these favors in return. Yet if you think about a system in terms of rewards and sanctions, the restrictions on rewards seems substantial.

Ironically, although the rating system clearly brings out an overall understanding of which vendors are competent and which are not, it has not given the VNS as much leverage as it would to, say, Toyota, in dealing with its subcontracting relationships. So far, according to the Director of Vendor Administration, some vendors have been sanctioned by limiting their volume, either by limiting the geographical area they can serve or the total hours they receive, but most have not actually experienced a decline in caseload. VNS's demand is growing so fast that it cannot afford to let subcontractors go. VNS wants its good subcontractors to grow rapidly; at the same time, growth can create problems for quality and control.

The VNS pays a uniform rate to all subcontractors, which removes price as an incentive for compliance and quality, and leaves only volume and types of cases, as mentioned. One source of tension for CHCA, then, is that they are unable to realize a lot of benefit from this particular reward because they grow slowly within the limits of their training system. Other important rewards for them, like easy access to afternoon hours cases, are not provided for in the rating system, nor even mentioned as an issue.

Yet it also seems to me that the rating system's focus on quality issues has made best practices a more articulated issue in the subcontractor market. While some firms may be uninterested in making the kinds of changes required, if the VNS is serious about sanctions and about terminating poor quality subcontractors, these practices will necessarily become more widespread. This can be a positive effect of the rating system, although it may be undermined by the tensions of monitoring. At some point, if VNS continues to increase its detailed requirements, it may be creating a kind of vertical integration; though subcontractors may continue to have separate identities, their internal operations will be so directed that they really function as divisions of the VNS.

One wonders, however, what the subcontractors will actually do. Some of the larger subcontractors seem to be the branch offices of national companies whose quality is not as good. The VNS needs these subcontractors, though, because they handle so much volume and would be difficult to replace. On the other hand, these subcontractors are also the ones most driven by national managers and stockholders to meet a certain bottom line. Against these kinds of structural pressures, will the VNS's moral suasion and limited sanctions have a substantial effect, if the price of quality is real dollars? And is the rewards system really complete as well? As the VNS addresses more subtle and qualitative issues around quality, can they do so successfully without drawing in their best subcontractors more?

The VNS is currently pursuing a strategy of rewards focused on the aides themselves, even though it does not employ them. It is sponsoring an awards program that will make $100 cash awards to aides who are "spontaneously" recommended by nurses for their quality care. The subcontractors are invited to participate in one of

three ways--to hold their own awards ceremony, to invite the VNS to give the awards at an annual event, or to have a joint event at VNS to present awards to aides from several subcontractors. VNS's intent is to raise the issue of quality yet another way, without getting into questions of pay, which they prefer to leave to the subcontractors. VNS funding for the awards will allow about 20% of the aides to receive them, which is a substantial number. However, this seems to me like an arbitrary way to deal with the quality issue, and to raise once again the confusion about whether subcontractors should really function like divisions of VNS, or as independent companies.

A final point is that in the current competitive system in this market, CHCA faces a dilemma; as their best practices are disseminated in the market, they benefit the competition. Without cooperative practices or institutions to increase CHCA's opportunities, it seems that the competition-cooperation model that Best described is not complete here. Competition alone, he stressed, could cause markets and firms to decline by removing the ability to build up sector infrastructure. This market seems to waver on this edge, though it has been improving slowly over time.

In the next section, I will draw from my case studies of the New York market and of this one subcontracting relationship to outline the dynamics of the market, look at how effective they are in creating quality of care and quality of work, and consider how the tensions between public purposes and market incentives might be altered. My purpose is to offer some framework for developing and evaluating possible changes in the structure of the market in order to meet its public purposes better, while maintaining its efficiency and innovativeness.

Chapter 5 Analysis

My original proposal in this thesis was that through looking at the market structure and especially the dynamics of its subcontracting relationships we would better understand how the home care market could serve public as well as private purposes, how to make decent jobs a goal as well as good patient care, and how quality of care and of jobs could be improved. CHCA as a firm achieves these goals by choosing a business strategy of high quality care combined with worker-centered management policies and worker ownership. However, their effectiveness is blunted by lack of support from contractors, market institutions or government policy, three areas of market structures that we have discussed. The internal consistency of their strategy does not alleviate their struggles with an external environment that is not supporting their business in achieving its social as well as business goals. Administrators at CHCA have felt increasingly frustrated and pressured by aspects of their contracting relationships that interfere with their business strategy. They have not found a way to change those relationships, in spite of considerable recognition from other quarters for their accomplishments. As Best (1990) told us, for one firm to pursue a strategy of continuous improvement without supporting relationships and institutions in its sector is a "Herculean task."

Yet when I looked at the VNS, CHCA's major contractor, I found them to be innovative as well. Their leadership has made a firm commitment to increasing the quality of patient care by cultivating an attitude that patients are "the customer." Their

size and financial resources allowed them to make a major investment in information systems, which are being used not only for increased efficiency in processing information about case assignments and billings, but to monitor a number of quality parameters. Though still being refined, their rating system has apparently improved awareness of quality issues among both their own staff and their subcontractors, and has had some impact on the dissemination of best practices among subcontractors.

In the previous section, however, I raised some doubts about the long-term effectiveness of the VNS rating system, based on obvious incentives to cheat, and the lack of strong rewards or sanctions in the system. If the VNS continues to try to regulate quality down to details such as how to introduce your company to a patient, they will set up an environment that actively runs counter to their interest in supporting their best subcontractors. Such regulation-oriented systems increase overhead for all firms without allowing the good firms to reap rewards (except growth) for their quality.

In this section, I will propose that the constraints on CHCA come down to the lack of cooperative, or partnership relations with their contractors, and that constraints on the VNS rating system's effectiveness come down to the same point. These two organizations have seemingly compatible goals in some respects, particularly their equal commitment to social goals, and especially their commitment to good patient care. The incompatibility I find between their strategies lies in their different perceptions of the relationship of quality of working conditions for aides to quality of patient care.

CHCA's focus on working conditions for aides requires them to consider not only subcontractor hourly rates (where VNS is clearly a leader) but full-time hours and

low overhead costs (where VNS makes no commitments and increases costs.) It is in negotiating better resolutions of the second two issues that partnership advantages for CHCA would lie. For the VNS, advantages would lie in better understanding how to promote its best subcontractors and cultivate new high-quality ones to be able to increase the volume of cases being handled by high-quality firms. I will also argue below that a more flexible, partnering set of contracting relationships would leave both sides better positioned to deal with the inevitable changes in this market that will occur as government, business and the public wrestle with health care reform.

Applying Theory to This Study of the Home Care Market

To develop my argument about the importance of subcontracting relationships to high quality outcomes in the home care market, I will first refer back to the previous chapter on theories, then comment on issues that have emerged from the case study. In the last chapter, I will extend these ideas to a discussion of what kinds of changes might be made in this market, and by whom, and conclude with a brief discussion of lessons learned. Five points emerged from my previous discussion of theory concerning firms and markets:

1) To evaluate an innovative firm's success we must also understand its market.

2) Large contractors can achieve better quality outcomes through partnership relations with subcontractors.

3) The details of the production process are key to understanding both internal and external aspects of a firm.

4) Efficiency in the economy means more than low price; "X-efficiency" refers to savings realized from best practices, versus low prices.

5) The state in the U.S. has more power than it generally recognizes to shape markets through its property rights actions. Changes in structures of markets

(governance regimes) come from many sources; a "search process" of experimentation and negotiation in a political arena determines the outcomes.

1) The Firm and the Market

CHCA continuously innovates their systems and management; as I was finishing up this thesis I had the opportunity to see a new management tool they are working on, a "management scorecard" that provides a framework for evaluating their performance relative to their three aims--creating decent jobs, providing good care, and remaining financially viable. This kind of continual innovation through close attention to detail, and the progressive management style they have developed for their worker-owned company, makes a rare package in semi-skilled service industries. It fits Best's description of the "new competition" well. The question raised here is how the market creates an environment that supports such innovative firms; as discussed above, this cohesive environment is lacking so far in the home care market.

Michael Best, in The New Competition, comments that

> "one prerequisite for inter-firm cooperation to enhance competitiveness is the negotiation of a well-defined purpose for cooperation. Establishing a purpose is to develop and implement a sector strategy which builds from, and acts back upon, the individual enterprise strategies within a sector. A second prerequisite for successful inter-firm cooperation is a means of monitoring and enforcing enterprise actions to counter the free-rider tendency...Strategically managed inter-firm associations can promote the long-term development and competitiveness of a sector; non-strategically managed inter-firm associations will likely have the opposite effect." (Best 1990, 18)

The well-defined purpose for cooperation that could be envisioned for the home care industry to be as competitive as possible in its public purposes as well as the market would be providing quality of care and quality of work at the lowest reasonable cost. Less demanding forms of cooperation, for instance, informal

information sharing among subcontractors regarding management or hiring, do not build up the sector infrastructure of which Best speaks.

This purpose, however, would have to be clearly articulated by a major player in the market to be effective, whether by state government or one of the private actors in the market. The home care market's relative newness and rapid changes in its policy environment have caused structures of the market, firm relationships and inter-firm associations to change a good deal over time, as far as I could observe. It is not a well-established environment in which to build relationships focused on the long term. Two trade associations exist in the state (and appear to function as lobbying groups), and CHCA initiated a city-wide Home Care Working Group that accomplished some purposes. From my observations, however, the dominant organizing principles of the market right now are the relationships between contractors and subcontractors, the competition between agencies at both levels, and government policies. Looking at the market, therefore, we must also think about how "strategically-managed interfirm associations" might be formed that could systematically favor organizations that produced better quality and provided better working conditions.

2) Contractor-Subcontractor Relationships

The current market structure does not support highly productive contractor-subcontractor relationships. The hospital-affiliated agency with which I spoke is focused on "efficiency" in the old-fashioned low-bid sense. It is successfully generating revenues but making it impossible to provide good wages to aides. I do not know whether the hospital-affiliated agencies are better able to control the quality of care, independent of the quality of jobs. The Executive Director of Montefiore told

me that their subcontractors know that their contracts will be terminated if their quality is unsatisfactory. Montefiore reduced the number of its subcontractors from 32 to 12 under its current administration, so the threat of termination is not trivial. However, they have no formal rating system by which one could compare the quality of care on some parameter such as lateness or lack of coverage. The only quality monitoring in their system of which I am aware is through the reports of nurses and coordinators; how this information compares with the rating system remains to be learned.

The major issue with the smaller and lower-paying hospital-affiliated contractors in terms of the concerns raised in this thesis, is that they are less able to realize economies of scale, and that they have less incentive to respond to the issue of quality of jobs for aides because they are more pressured to contribute to institutional overhead. Even if they can achieve high quality in terms of low rates of lateness, lack of coverage, theft, or other kinds of patient care problems they are not contributing to achieving the second important outcome of the market, which is good jobs for semi-skilled aides.

The VNS, in contrast, already has made a commitment to improving quality of care through direct monitoring and involvement with its subcontractors and it pays higher reimbursement rates to them, allowing better working conditions for aides through companies like CHCA. However, I would describe VNS's relationships with subcontractors, drawing on Bradach and Eccles, as partly market (a large number of subcontractors supplying similar services) and partly authority (in the sense of market power over their subcontractors.) Evidence of their authority comes from their ability to introduce their new rating system with large additional demands on the subcontractors with little negotiation. The third control mechanism cited by Bradach

and Eccles, trust, is the least present. While the VNS administrator may rely on individual subcontractors to deal with problems or give her feedback, there are not strong reciprocal relationships and strong rewards for good performance. Good subcontractors are not brought into closer relationships that allow them to take advantage of VNS resources to improve their own quality and efficiency or to cooperate with the VNS to improve their mutual operation. VNS relies instead on describing quality in such detail that each of its contractors is equally burdened, whether they are performing well or not.

The incompatibility between CHCA's and VNS's strategies appears around questions of the organization of subcontractors' work to facilitate better working conditions for aides and lower overhead to provide more wages and benefits. Not surprisingly, the VNS treats its subcontractors as part of an equation for quality service, but not as partners. The structure of the market, with separate subcontractors managing the semi-skilled labor, has been determined by issues that relate mainly to cost. The VNS approach brings out the contradictions of this market structure; while aides provide most of the labor, and most of the quality problems, they are not under the direct supervision of the agency responsible for case management. At some point, regulating every aspect of aides' work (and of their agency's contact with the patient) argues that it would make more sense to vertically integrate again to incorporate aides into the nursing agencies, eliminating an administrative layer and supervising quality of care and quality of jobs directly. However, cost issues so far continue to make subcontracting more desirable, and I would argue that there are additional benefits to the subcontracting system.

Subcontractors can give a voice to the aides and articulate how to make better

quality jobs for aides, perhaps better than could be done within one large nursing-and-paraprofessional agency--that is, if the subcontractors are allowed to act as that voice. Managing and training aides is a very different process from managing nurses and social workers, and subcontractor specialization may be effective. It may also create more effective management by allowing more subcontractors of smaller size, compared to a VNS complete with a very large number of home health aides; these smaller firms are potentially a better way to provide support to home health aides and keep them in stable employment (one of the two public purposes we have ascribed to the market). Subcontracting with partnership relations could lead to more creative practices than either vertical integration or the current subcontracting system.

Partnerships may also be the only way to tap into financial resources to support better wages and benefits for aides without reducing the amount of service that can be provided (or aides that can be hired). Partnerships could reduce overhead expenses, leaving more available for wages within the same reimbursement rates (a CHCA strategy), and could also build a case with the government that training and employment costs should be partially offset with welfare system funds, based on demonstrated success in hiring and keeping aides. Encouraging worker-owned companies would further add to the resources available for distribution to workers, since they would receive a share of profits as well as wages.

3) Understanding the Production Process

In the case of home care, the production process means assigning, covering and supervising cases, rather than a more concrete manufacturing process. However, the details of how it is done prove useful in thinking about how the market functions and

how to encourage firms like CHCA.

My first point is that for true quality of work for aides, mandating a wage level is not enough. Though steps have been taken in some cases to address wages[37], when they are not linked to hours of work as well, they offer little real improvement in working conditions. A report on home care in Massachusetts commented that required benefits for full-time workers seemed linked to a policy of part-time employment by agencies, to avoid the costs of benefits.[38] Advocates of quality care as well as quality jobs must make the link between wages and full-time hours.

Full-time hours are not just a financial matter; they are difficult to schedule. Morning care on half-day or shorter cases is most common, since the aide can get someone up and dressed and provide a meal, leaving them and possibly their families to manage the later part of the day. Scheduling all morning hours, however, means that aides who do not get the long-hours cases must work part-time. With effort, CHCA has been able to get afternoon hours for many of its aides, but there is no recognized policy between the VNS and its subcontractors that sets a priority on scheduling afternoon as well as morning hours. Full-time hours for aides means that nurses and coordinators must actively manage cases to create afternoon hours wherever reasonable, to consider the best interests of both aides and patients.

The coordinators are the key link between agencies and between nursing supervision and case coordination, and they are the decisionmakers who actually

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[37] The state legislature's pass-through increase for wages in New York, Massachusetts' Rate Setting Committee (mentioned in draft report on home care industry, Lois Stanley 1994, MIT).

[38] Ibid.

structure the workload of the aides and the subcontractors. CHCA learned early in its existence that management's agreement to support their full-time hours objective did not translate into scheduling. Until they established good relationships between coordinators in both agencies, they were unable to get the afternoon hours. Improvements in the market, I would argue, depend in part on working closely with coordinators from both contractors and subcontractors to articulate issues about quality of work for aides and for patients and to ensure that coordinators understand each others' responsibilities.

Other points that should be shared to improve the system include best practices on both sides of the subcontractor relationship. While I am not familiar with best practice issues within the nursing agencies, I learned that selective hiring and training are two important components of good practices on the part of subcontractors. These and other practices, including support for aides, worker ownership (in the case of CHCA) and methods of handling data and information for efficient administration and reduced overhead, are all vital to the effectiveness of subcontractors.

I would argue that the government can never be as familiar with the production process as are the firms that do it. While government might appropriately set targets for such issues as hours, wages and benefits, and quality of care as it can be measured, the best solutions to production issues come from firms working together.

4) Efficiency

Defining efficiency means, in large part, defining the frame within which you look for it. For instance, Williamson defined a whole area of costs, transaction costs, that had not previously been considered. Using this frame, he then found rationales

for a whole set of decisions that previously could not be explained in terms of efficiency. In the home care market, you can look at efficiency at a number of levels. For instance, Montefiore cites its efficiency of operations as the reason that they have been able to absorb a cut in their Medicaid rates and still provide the highest divisional contribution to the Medical Center's bottom line. I have questioned whether this is truly efficient if you look more broadly at the effects of this agency's policies. If their subcontractor reimbursement rates cause subcontractors to economize on wages and benefits for their home health aides, efficiencies in terms of both quality of care and the welfare system may not be realized. The question is who will decide if contributions to a hospital's overhead and capital budget are as efficient a use of home care funds as higher wages, from society's perspective.

Between the micro- and macro-levels of efficiency raised in this question lie various kinds of business practices captured in the concept of X-efficiency mentioned in Chapter 2. An example of the hidden meanings of cost efficiency came out in my conversation with the Vice President of Partners-in-Care. Partners' mission is to keep costs down, so it can return more profit to the VNS on its cases. Right now, its average costs are lower because it is expanding rapidly, and new aides make less than experienced aides. Building a system on efficiencies of this kind would obviously work counter to the aims of improving working conditions for aides, because it provides an incentive to let experienced aides go.

CHCA's efficiency in administration and in profits distribution to workers qualify better as true X-efficiencies--practices that make its business run better without being strictly focused on low cost. In looking at relations between contractors and subcontractors, however, there are few X-efficiencies being realized in the system.

Contractors pay little attention to the question of subcontractors' overhead costs, and I heard of no significant practices to realize economies between contractors and subcontractors. Examples of possibilities would be cooperation on computer systems that allowed subcontractors to run one data system in their own offices that could supply needed information to all their contractors without double entry. Another issue that is prominent at the interface between contractors and subcontractors is verifying aides' personnel records in terms of certification, medical tests, references and in-service training. Each contractor maintains a quality assurance or contract compliance department, whose job is to audit subcontractors' personnel records to confirm that they are in compliance with the state's and the contractor's requirements. Thus, each subcontractor is subject to audits from all their contractors. Centralizing these basic documentation requirements in some way could reduce time spent on details and increase time available for supervising the quality of care, or economize on administration costs in favor of wages and benefits.

These are only a few examples, but they suggest that active promotion of efficiencies in the market could realize gains for both quality of care and quality of jobs, initially with little additional total costs.

5) The State's Role and the Political Arena

My methodology in this study has been qualitative, using interviews to understand people's perceptions of their firms and the market context, and I have not investigated the laws and policies that have shaped this market, nor the complexion of the political issues that affect it. A few observations from my interviewing can be made, with the caveat that this should be an area of further study.

Government's role in the home care market has generally been to regulate a minimum set of standards largely focused on certification, medical tests and in-service training of aides, and to set the rates for reimbursement. In the case of the labor adjustment to the Medicaid rates, the state stepped in to improve working conditions, but this adjustment was later folded into the reimbursement rates, releasing it from any specific targeting. The kinds of quality issues that the VNS is addressing through its rating system are not addressed by government regulation.

The government's interests in both quality of care and quality of jobs for home health aides, however, has not been clearly articulated. In fact, it is difficult to see who could make this connection, and what their relationship to the overall system would be. Nevertheless, discussions of economic development suggest that when the government sets high standards for its purchasing activities, it benefits both from the quality of its purchases and from the improvement in the strength of the firms with which it does business. (Sabel 1993)

In setting policy to guide markets and to maximize the effectiveness of government purchasing dollars, policy-makers need to take account of the detailed workings of markets, and to continue to collect information about how firms are responding to their incentives. Questions of what kinds of firms, and what kinds of relationships they are forming, what kinds of jobs they are creating, and what kind of quality emerges are all very relevant to the effectiveness of government spending. The premium put on learning how to foster competitiveness in manufacturing should be applied to all kinds of government purchases. In fact, applying it to service industries, and especially to healthcare may be as important to the economy as manufacturing, given the trends of employment and production that we see moving toward services.

I would argue that looking at profit incentives and how they are working is particularly important. It is in government's interests to have government dollars support as much locally based industry as possible, to create as many jobs as possible, balanced against paying reasonable wages, and not to provide excessive dollars to either individual shareholders and owners or to institutions who are paying very low wages.

In the next chapter of recommendations and conclusions, I will propose some issues for government policymakers to consider, and consider the political arena and sources of change.

Chapter 6 Recommendations and Conclusions

My inquiry into the home care market sought to answer the question, can the market be made to foster more innovative companies like CHCA to improve the care provided to patients and the working conditions for home health aides? I have made a case that the place to look at is the relationships between contractors and subcontractors in the market, to understand how profit and surplus incentives and business practices play out in terms of outcomes and to make recommendations that take both realities and possibilities into account. In this section I will offer some recommendations and conclusions.

Strategic change, especially at the market level, is not easily directed; crafting strategy incrementally often reveals more than anyone can plan ahead of time. (Mintzberg 1987) Yet, at the market level, the difficulty is creating institutions or even understandings that allow this incremental strategizing to occur with a common purpose. In a recent article, Charles Sabel (1993) proposes that through joint formulation of goals, firms (or firms and the state together) can incrementally and experimentally develop new products and processes, "learning by monitoring" in contrast to monitoring for performance only. His argument is similar to Best's, but focuses more on institutions and processes of change than on the strategic firms of Best's presentation. These "discursive institutions", as Sabel calls them, might deal with inter-firm issues substantively in terms of products and processes, or with firm-state issues "primarily [formally] - better rules for encouraging learning by monitoring." (Sabel 1993, 30) Sabel favors this learning process through discursive

institutions over regulation precisely because of the difficulty of determining outcomes ahead of time:

> "The upshot is that the most careful efforts to canvas the precondition of cooperation put the responsibility for events precisely where learning by monitoring suggests it should lie: with those who see and bear the immediate consequences of their decisions. They can never know the outcome of their efforts at cooperation in advance. But the successes of learning by monitoring at all levels of economic development shows that in speaking of their possibilities they are exercising the very faculties needed for realizing them." (Sabel 1993, 55)

In offering some recommendations, I will first consider specific operationally oriented changes that would be within the control of the VNS and its subcontractors, since that one sub-system represents such a large part of the market. Then I will consider more generally what kinds of policy and market changes might foster both the specific outcomes of good quality care and jobs and the discursive institutions of economic development that Sabel describes.

Operationally Oriented Changes

Developments from its rating system project lead the VNS toward more contact with its subcontractors, including the dissemination of best practices in an effort to improve their below average subcontractors and the convening of a subcontractor advisory committee to meet with them and review updates of the ratings and other policy issues. Neither of these, so far, has forged the common purpose of which both Best and Sabel speak, though they have potential. The next step would be to develop systems together by working with their best subcontractors. While the VNS goes to some lengths to treat its subcontractors equally, and its rates are uniform, I argue that making distinctions among the subcontractors and finding ways to reward within their

rate structure would generate more improvements in the system.

By identifying a few key issues that would benefit subcontractors and be achievable within the current relationships, more could be accomplished. One of the most valuable issues the VNS could tackle would be a system for more consistently getting full-time hours for their good subcontractors' aides. From my limited observations, this would require setting out explicit goals for VNS nurses and coordinators to meet, and would be further improved by running cross-training sessions with coordinators from the VNS and subcontractor coordinators to learn what issues and difficulties arise on both sides when trying to give aides more hours.

Another area would be finding some way to lessen the demands on subcontractors in terms of information-processing and staff time that go into the new rating system. Without vitiating the system, it seems likely that a group of the best subcontractors working with the VNS would be able to come up with some streamlining suggestions that would concentrate staff time where it counts, preserve accountability, and also potentially provide some more rewards and incentives by creating tiers of supervision among the subcontractors. Those with better quality ratings could be treated differently, and allowed some economies on staff time, while those with lower ratings could be held to the full demands of the system until they demonstrated substantial improvements.

CHCA managers commented on the difficulties of maintaining their own data base while re-entering information into the VNS system. Another issue that is coming up now is that VNS and Montefiore are requesting that subcontractors fill out timesheets on their forms, rather than the subcontractors' own forms. CHCA administrators generate timesheets directly from their database system to be more

efficient; these new requests mean that they might have to go to hand-written sheets for each separate contractor. It also interferes with the company identity CHCA fosters.

The VNS could help favored subcontractors more substantially by helping to finance them. A small portion of their surplus revenues could be used for a loan fund to high quality subcontractors especially for expansion or improvements of their operations. More simply, "above average" subcontractors could get favorable payment schedules on their receivables.

Cooperation Goals

All of these issues come down to being able to do business efficiently, in order to keep costs down and to make profit or surplus funds available. The efficiency of the total system (the X-efficiency, if you will) may well be greatest if there is more emphasis on inter-firm cooperation and less on each firm trying to maximize its own strategy within the constraints of the market.

More active partnerships would be possible. The VNS or a group of subcontractors might initiate alliances that set certain terms for cooperation, using some of the criteria of quality of care and quality of work that have been discussed throughout this paper. The VNS is in the best position to head up such an alliance, since it has the information technology to support this effort best, both for tracking quality issues, and for tracking other administrative information. However, the importance of more subjective measurements of quality should not be underestimated. The VNS administrators already know that their "objective" criteria have generated numbers with various meanings and that interpretation of them requires understanding

the gathering techniques, the trends in reporting over time and so on. The importance of good working relationships in terms of the satisfaction of nurses and coordinators cannot be overestimated, nor can the importance of using subjective as well as objective measuring techniques.

Policy Level Changes

In setting policy to guide markets and maximize the effectiveness of government purchasing dollars, policy-makers need to take account of the detailed workings of markets, and to continuously collect information on how firms are responding to their incentives. What kinds of firms are forming, what relationships they have, where profit goes and what wages are paid, and finally what quality of product (home care in this case) result are all relevant to the effectiveness of government spending. The same premium that government places now on learning how to foster competitiveness in manufacturing should be placed on learning how to make all government purchasing create competitiveness and efficiency.

I am not able to address the full range of policy tools at the hands of the government, but can discuss a few points. One thing that I have come to believe is that government policies that attempt to address wage and benefit floors in isolation from other aspects of jobs are unsuccessful. Firms tend to respond by coopting policies, as when New York firms got the wage increase rolled into their rate, or by limiting their employment practices to evade requirements, as in Massachusetts firms' avoidance of full-time employment. The government's best interests are served by fully describing the jobs they want to generate, and then finding a way to work with firms that fosters the creation of these jobs. Requiring quality of care--that is, setting

standards for the services purchased--seems to me to be a key point. To the extent that high standards can be demanded along with decent job descriptions, the government will be tying together its various interests in the marketplace.

At this time in the New York City market, the VNS has the best quality monitoring capability. I would not propose that the government attempt to duplicate this system, but that they explore creative ways to work with any contractor who develops a good monitoring system to foster the subcontractors who perform well. In the same way that I propose the VNS improve its interface with subcontractors to improve the effectiveness of spending in the system creating desired outcomes, the government can review its interface with contractors. One area where improvements could clearly be made is in the confusion of rules from different kinds of coverage. Whether national health reforms or individual policy changes could facilitate this change to a more uniform set of regulations and payment streams, it would clearly improve efficiency.

For further research on home care to inform policy decisions, I would propose that a detailed study be made of government expenditures down through the system to the final care-giving. At each step along the way, the institutional structures and their budgets could be documented, with the actual expenses and pass-throughs to the next level, and the wages and profits made. Incorporated into this study also should be a similar scrutiny of government expenditures on welfare and training, looking at how the funds are spent and what the results are in terms of welfare and employment cycles for individual women, comparing home care to other jobs accessible to these women. By creating a public balance sheet for the whole system that deals with home health aides, trade-offs in government funding might be made available to support

positive change in the private market toward improving jobs and reducing welfare and training expenditures.

Good performance needs to be understood as well as fostered, however, and government regulators must create an ongoing institutional relationship with home care agencies at all levels of the system in order to monitor and learn from the changes that evolve, as opposed to taking a "hands-off" approach to the market and leaving private actors to come to their own solutions with no oversight.

This is particularly important if the government wants to encourage more innovative firms like CHCA or trend-setting non-profits like the VNS. Successful worker-owned start-ups are not common; CHCA has experienced difficulties in finding managers who work well in this environment, and obtaining financing from traditional sources, as well as struggling with the constraints of its subcontracting relationships. Nor is worker ownership something that all workers might want; the rewards of ownership entail risks as well. Yet a successful worker-owned firm, especially in a low-wage sector, increases distributional equity, both because of its wage and benefits priorities and because of the distribution of dividends to its workers. Policy-makers should investigate what conditions would encourage the formation of such firms, and increase their viability, not by subsidizing them but by making financing and technical assistance more available and rewarding success with some kinds of special considerations. Programs in several federal departments intended to encourage competitiveness in small and medium-sized manufacturers will be acquiring information about program models for working with firms and about the effectiveness of various kinds of services. Insights gained there might well be applicable to encouraging worker ownership in firms, particularly where they deal with

modernization through reorganization of work and increasing participation of the labor force as well as technology.

Government incentives to reward initiatives such as the VNS information and management systems for monitoring quality could also improve the value of government purchases for services like home care. Similar to the contractor-subcontractor partnerships that I have proposed, government-contractor partnerships with the goal of improving quality of services and quality of jobs together could be directed toward reciprocal learning rather than monitoring and regulation. Both levels of partnerships have the potential to make better trade-offs in the system among the different stakeholders, some of whom (e.g. patients and aides) are not currently represented effectively in the decision-making processes of the market. Non-profits may have a special status in the provision of services in this alternative system, because they are less driven by profit incentives and more able to respond to social goals.

If profits to private owners and shareholders are reduced through the encouragement of both worker ownership and non-profits, the government must address the question of resources for financing, the greatest benefit of the market system as it currently operates. Alternative sources of financing that have been explored for community development and creative financing schemes from the government itself may provide such resources.

Change in the Home Care Market Arena

In my discussion of theoretical frameworks, I referred to John Campbell and Leon Lindberg's essay on the evolution of governance regimes, and their proposition

that changes in the structures of markets occur through a "search process" initiated by pressures from a variety of sources. In relation to the home care market we can ask the question, from where could the kinds of changes I have been proposing come - what kinds of pressures and which actors could have such an impact?

I have already discussed the government and the VNS, two of the major players in the home care market in New York City; in this section, I will briefly review other actors and potential actions they could take that would tie into the strategies I have proposed.

Patients and Their Families and Advocates

While patients are the "consumers" of home care, their choices are limited, particularly if they are poor. In terms of reaching patients and giving them voice, advocacy groups could be strong allies for strategies to improve the functioning of the market.[39] Working on a strategy concerning contractor-subcontractor relationships is not a typical venue for an advocacy group, however, and would take some convincing, I believe. If groups were persuaded to campaign for these kinds of process changes instead of the regulatory and monitoring ones that are more typically the target of activism, however, they would help to place pressure on the government and on contractors. They could be included in partnerships in such ways as improving feedback and information on quality from the patients' point of view. As a source of ratings independent of the criteria and patient surveys used by the VNS, they could

[39] For instance, they joined in the city-wide coalition spearheaded by CHCA to press for reforms in the system.

lend additional credence to any government system of incentives and rewards for improving the quality of care.

Home Health Aides

In this review of the market, I have identified two kinds of organizations that give more voice to home health aides; progressive subcontractors and unions. The union has successfully improved working conditions for the home care attendants in the city system, but would be strongly resisted by the rest of the market. In terms of the strategies I have proposed, unions may be less effective participants than progressive subcontractors, simply because they have less control over administrative efficiencies, and cannot help directly in making the link between reduced overhead and increased wages that I propose.

Trade Associations of Subcontractors

The interests of subcontractors currently in the market vary considerably, as I indicated in my discussions above. Two progressive subcontractors, per my own interviews, have been active on the issues of working conditions for aides in a trade association, but I do not have any details on this organization's larger agenda and strategy. I noted also reports of some subcontractors working together informally on key issues, such as a recent meeting to discuss prevention of abuse of aides by patients and their families.

Given the current structure of the market and possibilities for changes in both the market structure and the policy environment, however, it seems to me that alliances between progressive subcontractors and contractors could accomplish more than the

hardening of positions between the two that might result from separate trade associations. The difficulty is in getting a major contractor like the VNS, or the government itself, to buy in to the strategy to begin with; here the lobbying pressures of all groups should come to bear. More research on the existing trade associations might bring out how their agendas could be guided toward new configurations of the market.

Trade Associations of Contractors

Similarly to subcontractors, the interests of existing contractors vary and may not further progressive strategies. I would argue again that looking for progressive alliances between contractors and subcontractors, especially targetting the VNS, would be logical. Natural alliances for contractors might include, instead of other contractors, agencies in related markets and subcontractors. It might make more political sense to look at these groups and their natural allies (e.g., other non-profits, or hospitals and nursing homes) for strategic initiatives.

Governments of the City, State and Nation

This area requires considerably more research than I have been able to do; the question is which levels of government would have the most flexibility in initiating new kinds of oversight of the home care system. Higher levels of government have more authority and more resources; on the other hand, they are more distant from the city home care market. The current administration of the City certainly favors markets over government and is desperate for cost containment measures; however, since it does not foot the major portion of the health care bill, and is not ideologically

disposed to the kind of government-market intertwining I propose, changes at this level might be less politically acceptable. At the state level, the home care market includes up-state as well as city interests, and is more complex. Strategizing by interested parties would be needed to develop a coherent plan to influence government policy; initiatives in the market might be the best starting place.

Foundations and Other Interest Groups

Foundations have played a significant role in CHCA's start-up and are providing substantial funding for replication of their model in other cities. I propose that these interested participants use their strategic resources to influence market structure in addition to firm structure. By funding further research on the interaction of market incentives and social goals, and of government policy and market structures, foundations and other interested non-participants in the market could conceivably further strategies designed to improve both the quality of care and the working conditions of semi-skilled labor.

Summary

Many interests and many actors move the home care market and shape its structure. Pressures to initiate and press a search process could come from a number of sources, and once initiated, such a process would be interactive. One of the greatest upcoming changes in the market environment is national health reform, followed by the potential entrance of new competitors such as nursing homes or large managed care companies. I believe that there is no one inevitable outcome from the search process, and that alliances of progressive actors throughout the market could

make a substantial difference in its future structure. Changes that moved the market toward a more flexible and responsive form, and provided demonstrable improvements in the provision of services (the quality of care) and in working conditions (the quality of jobs) would be most likely to protect the interests of a broad number of stakeholders and best justify the spending of government funds.

Lessons Learned

About the Home Care Market in New York City

The home care market in New York City has grown rapidly and evolved from limited and small scale nursing care to a large and complex market in only a couple of decades. Market forces, responding to government and insurance payment and regulation policies, have fostered certain kinds of relationships among firms, and these in turn have generated specific outcomes which I have examined in terms of quality of patient care and quality of working conditions for home health aides. I have proposed that failure to make the connection between government purchase of services and job creation for low-income women has led to inefficiencies and distortions in the market that could be addressed directly through changes in contracting relationships and firm structure. These changes could be fostered by either private or government initiatives (or both). The market offers more efficiency, flexibility and innovation than government bureaucracy generally does, but needs direction to best meet the interests of all parties, particularly the least powerful groups that participate (poor patients and home health aides).

About Innovative Firms and Economic Development

CHCA successfully addresses a broad agenda of economic development, good health care, and innovative changes in ownership and management. I have proposed that fostering more firms like CHCA is vital to improving the delivery of services and the creation of permanent jobs. I have also maintained that firms like CHCA cannot succeed to their potential without support from the market structure around them, and that incentives and rewards for such firms and for other innovators should be created throughout the market, using the resources of all possible players.

About the Applicability of Theories on Manufacturing Competitiveness to Service Industries

While this could be researched far more thoroughly, I believe that I have made a case for using insights from the literature on competitiveness and applying them to this semi-skilled, low-wage market. Other literatures on high-performance work systems, worker participation and other changes to the internal labor markets of firms would be equally relevant. Turning around large bureaucracies, whether for-profit, non-profit or government does not mean only trimming them down; it means re-orienting them to a continuously improving production process and improving the information flow from those workers who are closest to production to those higher up in the organization. Tying these ideas in with the external relations of firms on which I have focused would be valuable. The theories I drew most on, particularly Best's, emphasize the link between external and internal organization of production in the firm.

About the Importance of Market Structure Inquiries

Even within home care, no two markets are the same. The local conditions, even

the sheer size of New York City's market are not duplicated anywhere else. A general lesson that I believe can be applied from this study is the usefulness of investigating the specifics of market structure in any given sector and locality. By scrutinizing the existing firms, their relationships and practices and the incentives for them in the market structure, changes can be proposed that are based not on ideology alone but on concrete analysis. In the case of markets like home care, where the government has a large interest in several aspects of the market outcomes (including efficiency, quality of service and job creation) there is no substitute for detailed observation of the actual workings of the market for guiding policy.

Though I have reached the point in this project where I am more aware of what I do not know than what I have discovered, I am prepared to offer my thoughts with proper humility to a larger discussion. I hope that they may be of some use to those actors in the market with whom I was privileged to work, whose comments and additions will surely improve the argument.

INTERVIEWS

Zianna Bennett
Counselor, Cooperative Home Care Associates; March 4, April 21, 1994

Steven Dawson
Director, Special Projects, Home Care Associates Training Institute, Inc.; April 21, 1994

John Engel
New York City Human Resources Administration; April 29, 1994

Marki Flannery
Vice President, Partners-in-Care; April 22, 1994

Brenda Lowther-Mandel
Director of Vendor Administration, Visiting Nurse Service of New York; April 1, 1994

Susan Schulmerich
Executive Director, Montefiore Home Health Agency; April 21, 1994

Betsy Smulyan
Director of Operations, Cooperative Home Care Associates; March 4, March 31, April 21, 1994

Rick Surpin
President, Cooperative Home Care Associates; March 3, March 31, April 29, 1994

Jeanie Taylor
Manager of Patient Services, Cooperative Home Care Associates; March 4, April 21, 1994

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