The Regulation of Nursing Homes: A Comparative Perspective

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TWO PHENOMENA ARE COMMON TO NEARLY ALL developed market economies. The first is the growth of long-stay institutional care for the elderly, in line with demographic trends. The second is the use of State regulation of private interests to protect the frail, incapacitated, or dying elderly in these institutions. The question of how best to safeguard the interests of one of the most vulnerable sections of the population is as universal as the underlying demographic trends which have helped to prompt it. In this exploratory article, we examine some of the issues involved in the regulation of standards of quality of care—an approximate measure—from a comparative perspective. We do so by looking at the experience of the United States and Britain. Despite the differences in the context and scale of the nursing home industries in the two countries, they share a common concern about the problems of regulation. In the United States, there has been a long and continuing history of scandal about the treatment of patients and concern about fraudulent use of the public purse; the reports of the Institute of Medicine (1986) Committee on Nursing Home Regulation and of the Senate Special Committee on Aging (U.S. Congress 1986) are only the most recent in a long line of documents exposing the inadequacies of the system of regulation. In Britain too, the growth of the nursing home industry in recent years has led to increasing debate about the adequacy of the regulatory

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system for protecting the elderly although, until recently, there has been no concern about costs (Day and Klein 1987a).

The aim of this article is to explore whether there are any common themes that can be distilled from an analysis of how the two regulatory systems work in practice. The nursing home industries in the United States and in Britain contrast sharply in their scale and method of finance; individual nursing homes differ markedly in their size and management structure—even the definitions of what is meant by nursing home care are not the same in the two countries; finally, the legal framework and technologies and scope of regulation in the two countries are very different. Yet, as the evidence examined in this article shows, there are striking similarities in the problems encountered and in the styles of enforcement adopted in response. There is, in practice, a remarkable convergence in the regulatory *process* despite all the dissimilarities between the two systems and the contrast beween the formal regulatory *models* used. From this it follows, to anticipate our conclusions, that the debate in both the United States and Britain about how best to improve their regulatory systems could usefully examine what is common to them both: the special characteristics of nursing homes and the logic of the regulatory process itself. If there are regulatory failures (as there are, in both countries) the reasons, we argue, are to be found less in the nature of the systems of formal control than in an inadequate appreciation of the social environment of nursing home care. In turn, this implies that future policy should move toward a model of regulation which can encompass both formal and informal, legal and social control.

Risks and Benefits of Comparison

To compare the regulatory strategies of countries which differ so fundamentally in their health care systems as the United States and Britain is to risk the ire of specialists on either. Inevitably, a somewhat oversimplified picture wll emerge. Why then incur the risk? The reason for doing so stems from the logic of comparative studies (Ashford 1978; Marmor 1983). Such an approach helps us to avoid the danger of ethnocentric overexplanation or policy area overdetermination. That is, it allows us to guard against the temptation to explain everything

in terms of the characteristics of a particular national system or of a particular service within that system.

Our analysis is therefore shaped by a series of questions. Are there some issues common to all regulatory systems, across countries and across industries? Are such issues furthermore common to all industries within any given country, such as Britain or the United States, thus reflecting characteristics of the political and economic environment rather than those of a specific industry? Or are the issues of regulation in the case of nursing homes different from those which arise in the case of other industries within the same political system? And, if so, is there something special and unique about the nature of nursing homes and the care of the elderly, which makes regulatory issues in this policy area international, cutting across nations and differences in the political and economic environment? Only by asking such questions can we disentangle which problems of regulation are general, which are country-specific, which stem from the particular nature of nursing home care, and which derive from the context (political, organizational, and financial) in which the nursing home industry operates.

This article, moreover, adopts a comparative approach in a double sense. It compares both between and within countries. Its origins lie in a study by the authors of the regulatory process in Britain where only recently has there been the kind of rapid expansion in nursing homes that characterized the United States in the post-Medicaid era. It was this that led them to the United States to see what lessons could be learned from the American experience by comparing the two systems of regulation. There is a considerable body of literature that suggests there is a distinctly American model of regulation and that this is legalistic and adversarial, whereas the British and European model is informal and consensual (Kelman 1984; Majone 1982; Moran 1986; Vogel 1983; Wilson 1984). None of these studies deal with the nursing home industry. If their findings also held for the nursing home industry, it would seem reasonable to conclude that regulatory models reflect general national characteristics rather than those specific to the industry being regulated. Conversely, if their findings did not hold for the nursing home industry, it would seem reasonable to concentrate on the special characteristics of that industry when discussing regulatory issues.

To compare, however, the American and British models of regu-

lation—i.e., the formal characteristics of the two systems as set out in legislation and official regulations—does not necessarily tell us how they work in practice. Regulatory style—i.e., the way in which regulation is actually carried out by inspectors and surveyors—may be equally important. In the case of our British study, our concern was precisely to examine how national policy was implemented at the local level (Day and Klein 1985). This seemed an even more appropriate concern in the United States, given the diversity of social, political, and economic conditions and the evidence that regulatory practices vary from state to state (Institute of Medicine 1986). Accordingly, we carried out brief studies in two states, Virginia and New York, chosen because they represent different civic traditions or political cultures. While Virginia's political style, it has been argued, is distinctive "in its sense of honor and gentility" (Patterson 1968, 202), these are hardly the words that would be used to describe New York's. In this, our assumption was that if these two states had more in common with each other than either had in common with Britain, then indeed it would be possible to talk about an American model in practice as well as in design. Furthermore, it would follow that the problems of American regulation could correctly be ascribed to the characteristics of the United States regulatory system, and the way in which the nursing home industry is financed and organized. In contrast, if it emerged that there were problems or issues cutting across both countries and states, it would be reasonable to seek to ascribe these, in part at least, to the characteristics of nursing homes and their inhabitants.

In all this, our article represents only a first, rough cut at the subject, and this for a variety of reasons. First, we deal with only one dimension of regulation: i.e., the regulation of standards or quality of care. We do not deal with the regulation of either quantity or prices. This is because the regulation of standards is the only dimension common to both the United States and Britain. For the biggest difference between the regulatory systems of the two countries is, as we shall see, precisely that Britain does not try to limit entry into the nursing home market through certificate of need or similar procedures or to control charges. Second, our article represents a tourist's view of the American scene; it seeks to convey the shock of surprise which a new landscape produces on the outsider, and to pick out those features which perhaps have lost their ability to surprise the inhabitants, but does not attempt to provide a complete or detailed map. Lastly,

we do not attempt to assess the two systems in terms of their outcomes, i.e., which one is more successful in maintaining quality and preventing abuse. Not only is quality itself an elusive and difficult notion, which is precisely why the regulation of standards is problematic. But it is also the product of a complex, ill-understood process in which social, organizational, and economic dynamics may be just as important as the regulatory system, and, at present, we lack the understanding needed to separate out the contributions of these factors.

In line with the logic of our inquiry, we start by reviewing briefly some of the wider literature dealing with regulation. This is not only helpful in identifying what is special about nursing homes as such but also in alerting us to issues of regulation that cut across countries and industries. From that we move on to sketching out the very different role and scale of the nursing home industry in the United States and Britain, before examining their regulatory models and processes in detail.

Theory and Practice of Regulation

What can be learned from the general literature of regulation? It is a literature that is as wide-ranging as regulation itself in modern societies. It deals with the regulation of drugs and processed foods, with clean air and the pollution of water. But it is a literature primarily concerned with quality in its varying aspects, from the quality of the air we breathe to the quality of the working environment. From it can be filleted out three themes that help to organize the discussion of regulation, whether of nursing homes or any other industry. They are: general models of regulation, problems of implementation, and differences in national styles. In what follows, this section briefly picks out the main points generated by the literature, in order to provide benchmarks for the subsequent discussion of what (if anything) is special about the regulation of nursing homes.

To start with, there is general agreement (Hawkins and Thomas 1984), that there are two "contrasting systems, styles or strategies" of regulation. On the one hand, there is the *compliance model.* Here the emphasis is on preventing problems, on encouraging the investment of time and money to improve the situation; the inspector sees his or her role as being to cajole, negotiate, and bargain. Legal prosecution

is seen as a last resort. The social relation between the regulator and the regulated is valued as a means of assisting in the discovery of future problems. On the other hand, there is the *deterrence model.* Here the emphasis is on punishing wrongdoing. The style is accusatory and adversarial. Recourse to formal legal proceedings is almost automatic. Effective punishment of rule breaking, it is assumed, will lead to improved behavior in future. In practice, most regulatory systems tend to be a blend of the two strategies; the distinction is helpful, however, in identifying the bias of any particular system.

Complicating the picture is the fact that the rules being enforced may be ambiguous or imprecise. Assumptions about what is desirable are conflated with assumptions about what is feasible. The resulting aggregation of scientific, technical, economic, and political criteria is not only ad hoc but also logically inscrutable (Majone 1982). From this it follows that the notion of an offense is problematic: the "facts" do not speak for themselves, but are interpretative judgments made by the regulator (Hawkins 1984). In turn, the judgments may depend on the way in which the regulators see the behavior of the regulated (Kagan and Scholz 1984). It is the context that gives meaning to any breach of the rules. If the organization or firm being regulated is seen as an amoral calculator, prepared to risk breaking the rules in order to maximize profits, then an aggressive deterrent strategy is likely to be pursued. Any breach of the rules will be interpreted not as an accidental slip-up, but as a deliberate attempt to get round the system. Conversely, if the firm is seen to be organizationally incompetent, then the regulator is likely to see himself or herself as a consultant. Any breach of the rules may well be attributed to organizational failure, rather than as the product of deliberate intent. Lastly, if the firm is seen as a political citizen, responding to what is perceived as the reasonableness of specific rules, or the lack of it, then the regulator is likely to try persuasion and bargaining.

All this emphasizes the role of discretion in regulation. Inspectors and surveyors are examples of "street level" bureaucrats (Lipsky 1980) whose personal values or style may not necessarily be the same as those of their employing agency. If inspectors and surveyors often see themselves as wheeler-dealers, whose skill lies in getting cooperation by means of bluff and persuasion and whose ability to gain compliance may depend on their skill in dispensing technical advice (Bardach and Kagan 1982), this may be at odds with the managerial philosophy

of a regulatory agency that sees its role as enforcing the letter of the law.

The tension between compliance and deterrence models becomes more apparent still if account is taken of another characteristic of most systems of social regulation. This is that, unlike the criminal law, they are not primarily concerned with individual acts but with organizational behavior over time. Individual acts (e.g., the emission of noxious fumes at one particular point in time) matter chiefly insofar as they indicate an organizational failure (e.g., maintaining inadequate control over production processes). The point is well made in a British study of water pollution control:

> In the more familiar areas of behaviour embraced by the traditional criminal law, compliance usually means refraining from an act. But in pollution control compliance often requires a positive accomplishment, sometimes with major economic implications. Time and money have to be spent in one form or another, in planning, buying, building and maintaining compliance. The result of all this is that pollution control staff must display patience and tolerance, rather than legal authority, for their goal is not to punish but to secure change (Hawkins 1984, 197).

From this it follows that regulation can usefully be analyzed in terms of ongoing social relations between regulators and regulated, rather than as a one-time legal process.

So, from an American perspective, Reiss (1984, 33) argues that in simple societies social control, or regulation, is exercised through the capacity to observe, monitor, and directly intervene in behavior. In complex societies, however, "where one cannot directly observe, yet seeks to control," regulation is built on "trust relationships." To stress the importance of trust is indeed to bring together many of the points made in this section. If one of the characteristics of regulation is "an all-pervasive uncertainty" (Hawkins and Thomas 1984, 8)—uncertainty about the precise definition of standards, uncertainty about how much time to allow for improvements to be made, uncertainty about whether to interpret a breach of the rules as a symptom of chronic failure or as a one-time accident—then it is perhaps inevitable that much depends on the "trust relationship' between regulators and regulated. And this will be particularly so in the case of institutions like nursing homes where, for most of the time, it is impossible to observe directly what

is happening, where change can be rapid and uncertainty is high on all the counts listed above.

But before turning to the specific case of nursing homes, one final theme remains to be explored. This is the difference, already touched on, in the national regulatory styles of the United States and Britain. The United States differs from Britain, and indeed from most other Western societies, in the sheer extent of regulatory activities. Where other countries rely on direct forms of public intervention, such as the public provision of health facilities or public ownership of the railroads, the United States tends to rely instead on the public regulation of private activities. America passed its antitrust legislation, a triumph of market ideology, in 1890 and 1917; Britain waited until the 1960s before passing its Monopolies Act in a halfhearted attempt to encourage the kind of competitive behavior taken for granted in the United States. This may be why the debate about deregulation in the United States has the same highly charged, ideological tone that the debate about the privatization of nationalized industries has in Britain (Wilson 1984, 204–5). In contrast, regulation in Britain, as in most West European countries (Majone 1982) and particularly Sweden (Kelman 1984), is a low-profile activity. It tends to be politically uncontentious. In turn, there appears to be a consistent difference in the regulatory styles of the two countries, cutting across the industries being regulated:

> If one compares the British and American approaches to insurance regulation, equal employment, banking regulation, consumer protection, occupational health and safety, or securities regulation, a clear pattern emerges: in each case Americans rely heavily on formal rules, often enforced in the face of a strong opposition from the institutions affected by them, while the British continue to rely on flexible standards and voluntary compliance—including, in many cases, self-regulation (Vogel 1983, 101).

Explanations for this divergence vary. Some stress differences in the political cultures of the two countries; in the United States businessmen are seen as predatory competitors in a way that is not the case in Britain (Vogel 1983). Others put more emphasis on differences in political institutions and the extent to which they promote cooperation between industry and government (Wilson 1984). But from the perspective of our interest in nursing homes, it is the unanimity about the consistency of the pattern that matters. If Britain's approach to

regulation seems to conform to the compliance model, America's appears to be nearer the deterrence model. If the style of British regulation is consensual and informal, America's is adversarial and legalistic. If the former stresses cooperation, the latter produces conflict. So we would expect the regulation of nursing homes to conform to this pattern.

There is, however, a tension between differences in the national styles of regulation and growing convergence in the characteristics of the industries being regulated. As Moran (1986, 201) concludes in his study of the regulation of financial markets in the two countries, "National political cultures impose their own regulatory styles; the increasing structural similarities in markets encourage regulatory convergence." If, in fact, the social control of nursing homes raises common issues which cut across national systems of provision—issues specific to the characteristics of the industry—then we might also expect to find some similarities in the processes of regulation. So we might expect that the regulation of nursing homes could turn out to be, like the regulation of financial markets, a study in convergence stemming from shared characteristics and shared problems.

The Two National Systems Compared

The health care systems of the United States and Britain reflect their societies. Both these very different societies have, if to varying degrees, accepted the notion of State responsibility for the availability of medical care (Fox 1986). But the way in which this commitment has been implemented is very different. In the United States, a heterogeneous society with an ideology hostile to direct State involvement (King 1973), this generally means private provision publicly financed. In Britain, a far more homogeneous society with a long tradition of paternalism in social policies, this generally means public provision publicly financed. In turn, the formal structures of regulation in the two countries reflect this fundamental difference. That of the United States has followed money, and developed largely to protect public funds; that of Britain, set up much earlier, has its origins in professional self-interest. The United States system is designed to regulate comprehensively quantity and prices, as well as quality; that of Britain

is concerned only with quality. In what follows, we shall elaborate on each of these points.

Historically, the provision of long-stay institutional care for the elderly in the two countries has a similar origin. In each case, nineteenth-century public poorhouses and mental hospitals provided shelter and accommodation for the sick needy and destitute, including the poor elderly, who did not qualify for voluntary or religious care. But in the twentieth century the pattern of development has increasingly diverged, especially over the last 40 years or so. In the United States, the growth of long-stay institutional care for the elderly has been a largely unintended by-product, first, of income maintenance policies (Waldman 1985) and, in the 1960s, of medical insurance programs (Vladeck 1980). The type of provision has followed the availability of public funds, although of course the United States could have chosen to follow a different pattern of development. And since the demands funded by national and state governments under the Medicare and Medicaid programs are for *medical* care, the market responded by dramatically expanding the number of nursing home places. In turn, as we shall see, the nature of the funding shapes the way in which the function of nursing homes is perceived and the regulatory system is designed, since it is medical need that unlocks access to public finance.

In contrast, the British system of long-stay institutional care for the elderly still reflects its nineteenth-century origin. It has evolved, without any real break, out of the Victorian Poor Law—and indeed some of the nineteenth-century institutions are still in use. The Poor Law's function of caring for the infirm elderly is now divided beween the long-stay hospitals of the National Health Service (NHS) and the residential homes run by local authorities, while private and voluntary nursing and residential homes have developed to meet demands not met by either of the former. In theory, NHS hospitals respond to medical need, while local authority homes respond to social need, but in practice the distinction is blurred. The emphasis of public policy has continued to be on public provision, with private provision having a residual role. Indeed, the number of nursing home beds fell between 1938 and 1960 (Woodruffe and Townsend 1961). It was only in the 1980s that, as an unintended consequence of a change in the regulations governing welfare payments (Day and Klein 1987b), public finance started to be available on any scale for funding people in private

nursing or residential homes. Partly as a result of this, although partly also reflecting the increased prosperity of many of Britain's elderly, there followed a boom in private provision. While access to public provision is rationed according to criteria laid down by the service providers (i.e., family circumstances, housing conditions, the availability of alternative community services, as well as medical requirements), access to private provision financed by social welfare payments is conditional only on satisfying a financial means test. There is no requirement that public finance should be conditional on demonstrating either social or medical need. In analyzing the regulatory systems of the two countries, however, we shall concentrate exclusively on the regulation of nursing homes, ignoring the regulation of residential and other forms of institutional provision. For these are the most nearly comparable to skilled nursing facilities in the United States, i.e., they deal with the upper range of dependency (Bartlett and Challis 1985; Bennett 1986; Torbay District Health Authority 1985) and care is the responsibility of qualified nurses.

The regulatory models of the two countries reflect, in turn, the history, finance, and pattern of long-stay institutional care. In the United States, public regulation has followed public money (Ruchlin 1979; Institute of Medicine 1986, appendix A). As the federal government's financial involvement grew with the introduction of Medicare and Medicaid in the 1960s, so it introduced its own standards to supplement the state licensure rules. The regulatory system is thus designed as much to protect the public purse against fraud or graft as the consumer against ill-treatment or exploitation. It is a regulatory model shaped, moreover, by the assumptions that nursing homes are an extension of hospitals (Butler 1979) and their function is to provide medical care; that the protection of the public purse requires that they not be used by those who don't need such care; and that providers are supplying appropriate care at an appropriate price. In sharp contrast, the concerns of the British regulatory model are much narrower. It is a system that developed long before the very recent involvement of public funds in the financing of nursing home care and that, like the pattern of long-stay institutional care itself, is an example of historical continuity. In essence, Britain's regulatory model was devised in 1927, when the Nursing Homes Regulation Act was passed (House of Commons 1926; Abel-Smith 1964). Its passage reflected not worry about public funds or even public alarm about standards but professional

pressure. It was the College of Nurses which fought for regulation in order to protect its members against competition from unqualified staff or staff with qualifications other than nursing; some so-called nursing homes appear to have been used as brothels. From this follows one of the main characteristics of the British regulatory system even today. Nursing homes are statutorily defined as places where a qualified nurse is in charge. It is an emphasis which partly reflects the fact that the British nursing elite have traditionally had a higher social status than their United States counterparts, and partly that British nursing homes, unlike American ones, are seen not as an extension of the hospital but as providers of a different kind of environment and care. It is a model which, moreover, has proved remarkably resistant to change. Despite increasing anxiety about the infusion of public funds through the social security system (Audit Commission 1986), despite the growing salience of private health care as a political issue (Klein 1979; McLachlan and Maynard 1982), and despite occasional scandals in private nursing homes, there has as yet been no move to extend the scope of regulation beyond quality to the control of quantity and value for money. In this respect the present regulatory system remains, despite a flurry of legislative activity in the early 1980s, firmly based on the foundations of the 1927 Act.

Another contrast between the United States and British formal regulatory systems derives, predictably enough, from the fact that while the former has a federal constitution, the latter has not. In the United States, the regulatory function is divided between the states, responsible for the licensure of nursing homes, and the federal government, responsible for laying down the conditions of eligibility for federal funds. In Britain, it is central government, i.e., the Department of Health and Social Security (DHSS), that is responsible both for legislation and administration of the system. In practice, however, regulation is more devolved in Britain than in the United States. For example, the federal government reviews the way in which the states exercise their regulatory responsibilities. Further, the federal conditions of participation (Institute of Medicine 1986, appendix B) spell out in considerable detail what is required of nursing homes. In contrast, the DHSS delegates the regulatory role to the 192 English District Health Authorities (DHAs) which form the bottom tier of the National Health Service's (NHS's) administrative structure (the structure of the NHS differs in the component countries of the United Kingdom and,

to avoid confusion, we concentrate on England in what follows). It is DHAs which are responsible for licensing and inspecting nursing homes, for laying down staffing and other requirements, and if need be, for withdrawing their licenses. In all this, appeal lies not to the DHSS but to an independent tribunal set up in 1985. The DHSS itself appears to be disinterested in the way the regulatory system works; most conspicuously, it has no way of systematically finding out whether the 192 DHAs are, in fact, applying the same requirements or standards.

Moreover, the DHSS regulations are considerably less specific and less concrete than the federal conditions of participation in spelling out what those requirements or standards should be. There are some specific legal requirements, notably for record keeping and twice-yearly inspections. But, beyond that, the DHSS has not specified how the general aims of legislation—"to protect the public through ensuring that adequate standards of care and accommodation are provided" (Department of Health and Social Security 1981)—should be translated into concrete requirements for the physical layout, staffing levels, or operating methods. It delegated this task to the National Association of Health Authorities (NAHA), a nongovernment body, which in 1985 produced a set of model guidelines for DHAs (National Association of Health Authorities 1985). The standards set out in this set of guidelines have no statutory force but simply provide, in the words of the document, "a series of benchmarks against which each District Health Authority is invited to assess and set its own requirements." In comparing the federal and British regulatory systems, we shall be treating the NAHA guidelines as part of the latter, while also noting that their informal and quasi-voluntary nature may be one of the defining characteristics of the British regulatory system. In the case of the United States, too, national requirements are incorporated in a national survey instrument. At the time of our field studies, this was the 69-page federal form HCFA-1959 (now being replaced by the Patient Care and Services protocol for surveyors). In contrast, there is no equivalent national survey form in Britain and the NAHA's checklist for surveyors is a mere 9 pages long. By comparison with Britain, the United States, therefore, emerges (predictably) as being more legalistic and (surprisingly) as more centralized in its approach to regulation, the centralization of funding accompanying the centralization of regulatory control.

A final contrast between the two models stems not from differences in funding but from the fact that the United States lacks a cohesive system of public provision for health care in general, as well as for long-stay institutional care for the elderly in particular. In Britain, unlike the United States, the development of the regulatory system consequently reflects the implicit assumption that public provision is the norm. It is the public sector that regulates the private sector while itself is immune from regulation. It is the public sector that, furthermore, is supposed to set the standards against which private provision is assessed, and whose "publicness" in itself guarantees quality. It is an assumption that in recent decades has been severely challenged by a series of scandals (Martin 1984), and that has led to the creation of public sector inspectorates. The Health Advisory Service (1986), created in the 1970s, inspects services and institutions for the elderly across the public sector, while the more recently created Social Services Inspectorate (1985a) reviews services and institutions provided by local authorities. But while the reports of the inspectorates have underlined the fact that problems of looking after the elderly cut across public and private provision (Day and Klein 1987a) and that both sectors are equally scandal prone, they have not so far generated any explicit code of practice or standards for the public sector.

In summary, then, the United States formal model of nursing home regulation is more comprehensive, more explicitly legalistic, and more centralized than the British one—a conclusion that is a mixture of the predictable and the unexpected, reflecting differences in national regulatory traditions and in the funding of long-stay institutional care for the elderly. But how similar or different are the actual regulatory requirements as spelled out in the national legislation, codes, and conditions? To answer this question, as a preliminary to examining how the systems actually work at the subnational level in the two countries, we compare the actual provisions of the Skilled Nursing Facility (SNF) condition of participation (Institute of Medicine 1986, appendix B) and those of the DHSS regulations as supplemented by the NAHA (1985) guidelines; we use the SNF rather than the Intermediate Care Facility (ICF) conditions since it is skilled nursing facilities which offer the nearest functional equivalent to British nursing homes. To analyze the requirements, we use the familiar distinction between structural, process, and outcome criteria (Donabedian 1966) as our framework. And, as we shall see, the sheer difficulty of defining

what is meant by quality in nursing home care—a difficulty epitomized by the insistence of both American and British systems that "adequate" care be provided and their shared problem of defining what is meant by adequacy—tends to produce convergence, even while organizational and financial differences tend to drive them apart.

Structural or Input Requirements

Among the most striking characteristics of the two sets of formal requirements are their common insistence on spelling out in great detail how nursing homes should be designed, and the extent of agreement about what desirable standards are in terms of the physical environment. In each case, there is the same emphasis on fire precautions. In each case, there is a requirement to have standby emergency electricity generators. In each case, too, there is a minimum standard for the size of patient rooms; for single occupancy room, it is 107 square feet in Britain as against 100 square feet in the United States.

But similarities yield to contrasts when it comes to staffing inputs, which are shaped by the very different perception of the function of nursing homes in the two countries. Both countries require a registered nurse to be in charge of nursing services in each home; both, too, require that a qualified nurse should be on duty at all times, though not necessarily a registered nurse. Both countries, furthermore, recoil from specifying nurse-patient ratios because, as the British guidelines argue, there is too much variation in the characteristics both of the facilities themselves and of patients. In the case of British nursing homes, however, it is only the nursing inputs that are specified. Indeed, it is precisely the fact that a qualified registered nurse is in charge that legally defines a nursing home as such, as already noted. In contrast, the American requirement is for a "qualified administrator" to be responsible for the facility as a whole. In addition, the federal standards insist on a much larger degree of staff specialization—hence, such requirements as that there should be a "full-time qualified dietetic supervisor," which would condemn quite a large proportion of the much smaller British nursing homes to bankruptcy. Above all, the American requirements, unlike Britain's, demand a medical input, as much to protect the public purse as the patients themselves. Not only must each nursing home appoint a medical director; equally, each patient has regularly to be visited by a physician responsible for

certifying and recertifying the need for medical treatment. In contrast, patients in British nursing homes are merely registered, like all British citizens, with a general practitioner; it is up to the patients themselves, or those in charge of the nursing home, to decide when to call in a doctor. No assumption of a need for medical treatment is built into the British requirements.

Process Requirements

The divergence between the United States and British approaches to codifying standards becomes more marked still when it comes to the way in which they set about defining how nursing homes should be run. Even here, however, there are some common elements. In both cases there are the same stresses on certain administrative routines, such as record keeping and following set procedures for prescribing and dispensing drugs. But, more generally, the American approach is to insist in considerable detail on a pattern of routines and procedures, while the British approach is to promote a style of care by enunciating some fairly general aims. The differences follow, in fact, a systematic—and, by this stage in the analysis, familiar—pattern. While the American requirements suggest a rule-bound approach, the British ones tend to be informal and persuasive; while the former reflect a medical model of care, the latter tend to be based on a nursing model.

So the British guidelines point out that "the environment should, as far as possible, be domestic in character, and enable patients to retain their individuality and self-respect." Further, they emphasize that "it is important that the organisation and the attitude of staff reflect the need for patients to achieve and maintain maximum independence." But the implications of these general pointers for the actual running of the home are not spelled out; indeed, in the DHSS's circular to health authorities—setting out the latter's responsibilities—only two brief paragraphs are devoted to the way in which care should be organized, as against five paragraphs devoted to fire precautions (Department of Health and Social Security 1981). There could hardly be a greater contrast with the United States requirements, with their insistence on a managed package of care, starting with a patient care plan and a detailed specification of the social and rehabilitation services that must be available. If the emphasis in British regulations is on maintaining the independence of the patient, in the United States

regulations it appears to be on mobilizing medical, rehabilitative, and other resources on his or her behalf. If the former tend to stress the maintenance of a homelike atmosphere by the nursing staff, the latter stress the availability of technical services and use an energetic language of goal setting and the purposeful planning of care by multidisciplinary teams.

A further difference in the process requirements is the much greater emphasis in the federal conditions on protecting the rights of patients. If the emphasis on medical certification and review suggests a fear that public funds will be ripped off by nursing homes, the emphasis on patient rights suggests a fear that the residents will be exploited. The British guidelines have a laconic reference to the need to make sure that each nursing home has a room where patients may make any complaints to an inspector; they also have a requirement that patients should have access to a public telephone. But general exhortations about privacy, self-respect, and individuality apart, there is nothing like the federal requirement that each facility should have "patients' rights policies," including the *right* to be "treated with consideration, respect and full recognition of their dignity and individuality." Nor is there anything remotely resembling the extensive federal requirements to protect patients' funds against abuse. In the American case, the assumption appears to be that consumers need to be protected against predatory producers, while the British regulations reflect an implicit respect for the property right of providers. Add to this the traditional British suspicion of the language of individual civil rights and a reluctance to embody these in legally enforceable rules, and the differences in the styles of the nursing home regulations fall into the larger pattern of Anglo-American divisions.

Outcome Requirements

Here, at last, we come to complete convergence between the two national systems. Neither federal regulations nor the British guidelines have any formal criteria or requirements expressed in terms of desired outcomes for the patients themselves. In this respect, as in others, practice diverges from theory. The regulatory requirements as enshrined in national codes or conditions are at best only a rough and ready, and at worst a misleading, guide to what happens in the actual practice of regulatory enforcement. In the resolution, both systems do take

account of outcome in various ways, as we shall seek to demonstrate in the following sections where we examine the implementation of national policies in the two countries.

Political and Cultural Variations on National Themes

Q. How many Virginians does it take to change a light bulb?
A. Three. One to change the bulb, two to talk about how good the old one was.

Q. How many New Yorkers does it take to change a light bulb?
A. Thirty-seven. One to change the bulb, and a 36-member law firm to sue for damages under product liability.

Q. How many Englishmen does it take to change a light bulb?
A. Only one, but he won't do it because the bulb has always worked in the past.

From a comparison of national regulatory systems, our analysis moves on to examining how formal models are translated into policy practice. The evidence so far suggests that there are indeed systematic differences between the American and British national nursing home regulatory models, and that these are in line with what might be expected from the general approach to regulation in the two countries. Political culture in the largest sense—i.e., including the use of the law—matters. But do differentiations in political culture help to explain variations in regulatory strategies not only across but also within nations? And are such variations sustained through the policy implementation process, from the drawing up of codes to their enforcement in individual nursing homes? To answer the first of these questions, we compare the regulatory systems of New York and Virginia with those of Britain's District Health Authorities. In doing so, we will largely be telling the story of New York's exceptionalism. To answer the second of the questions, we turn in the following sections to a comparative examination of enforcement and implementation styles. In doing so, we shall find that while indeed variations in political culture continue to explain divergences in regulatory *strategies*, the common characteristics of the nursing home industry compel convergence in regulatory *practices* as we move nearer to the working level of inspection and enforcement.

In selecting the state of New York and the Commonwealth of Virginia for our American case studies, we deliberately chose to contrast a confrontational and abrasive political culture with a more consensual and conservative one. We could, of course, have picked our pair on other, deliberately simplified criteria; moreover, if the aim of our study had been to try to identify which characteristics of that protean and ambiguous concept—political culture—are linked to specific aspects of regulation, we would have had to use a much larger sample. For our purposes, however, this pairing allows us to ask whether Virginia has more in common with New York (with which it shares a national framework of regulation and finance) or with Britain (with which it shares some traditions of political culture). In the case of Britain, we use a composite portrait of English DHAs, rather than a pair picked out to match New York and Virginia, and this for reasons highly revealing of Britain's political culture. Not only are DHAs recently invented administrative artifacts, created by central government in 1982, and so lacking in any political identity, let alone culture. But also, despite the comparative vagueness and looseness of the national regulatory framework within which DHAs work, there is *less* variation in the models of regulation used locally than between New York and Virginia (Day and Klein 1985). Most DHAs have adopted the NAHA guidelines as the basis of their own codes, even though nursing home owners tend to complain about differences in interpretation on points of detail. In a relatively homogeneous and deferential country, with strong professional networks and shared attitudes among regulators, governments can promote common practices in the execution of national policies by using informal social pressures rather than formal rules and procedures.

The history and style of the regulatory systems in our three study areas follows the pattern of the differences in their political cultures. New York has a long history of headline nursing home scandals, especially following the rapid post-Medicaid expansion of the 1960s (Vladeck 1980). The image of the nursing home owner as a predatory, amoral calculator neatly fits the New York experience. In contrast, Virginia has no such legacy of well-publicized horror stories. Nursing homes, like other businesses, are part of the political landscape rather than, as in New York, targets on which politicians can sharpen their reputation for being defenders of the weak against the strong and possibly corrupt. In Virginia, the nursing home industry is strongly

represented in the legislature, and the ownership of nursing homes is seen both as a service to be regulated and as a property right; regulators tend to adopt a political bargaining style. In New York, the industry is seen as an adversary, to be treated with aggressive suspicion lest anyone think that the regulators are getting into bed with the regulated—the recurring American nightmare (Wilson 1980). In all these respects, the British system tends to resemble the Virginian in style. It is a system which, as we have seen, developed in response to professional pressures rather than public scandals, and which has had a low political profile.

All these differences are, however, not only consistent with variations in political culture but also are related to the particular nature of the nursing home industry in our three study areas, and it would be foolhardy to speculate on the precise contribution of these factors to our findings. Thus, New York (see table 1) has more nursing homes and beds than Virginia and the whole of England put together; furthermore, a high proportion of its facilities are in densely urban areas where all service industries, whether transport or education or health care, have problems reflecting the local environment and labor market, a point to be elaborated on later. Virginia has less than a quarter of New York's beds, and the growth of facilities in the metropolitan belt around Washington is a relatively recent development. In England, only 14 out of the 192 DHAs have more than 500 beds (Larder, Day, and Klein 1986), and even the DHA with the most beds has only one twentieth of Virginia's total.

The size of the industry, in turn, affects the size of the regulatory bureaucracy. Thus, New York (see table 1) has a regulatory staff of 300 or more than eight times as many as Virginia. This is a much bigger difference than would follow from the relative sizes of the industry and points to the independent influence of political culture. In England, by way of contrast, regulation is a cottage industry; the total estimate of about 100 regulators represents the full-time equivalents of mainly part-time contributions from NHS staff engaged in other duties (Department of Health and Social Security 1985). Only a handful of DHAs have full-time regulators. Neither Virginia nor England, therefore, faces New York's problem of internal control within the regulatory agency. Neither, consequently, is as preoccupied with self-regulation within the regulatory bureaucracy; both tend to

TABLE 1
Anglo-American Comparisons: Basic Statistics on Nursing Homes and Regulatory Systems

	U.S.	Virginia	New York	England
Population				
Total	229m	5.4m	17.6m	46.8m
Age 65 & over	25.5m	0.5m	2.14m	7m
(as % of total)	(11.1%)	(9.3%)	(12.1%)	(15%)
Age 85 & over	2.44m	0.045m	0.222m	0.5m
(as % of total)	(1.1%)	(0.8%)	(1.2%)	(1.1%)
Nursing Homes				
Number (1981)	13,326	163	570	820 (1983)
No. of beds (1983)	1,450,000	23,000	96,000	28,000 (1984)
No. of beds per 1,000 age 65 & over (1983)	55.8	40.8	43.1	4.0 (40.1)*
Rate of bed expansion 1981–1983	3.5%	11.4%	2.4%	35% (1982–1984)
% < 60 beds	NA	26%	15%	83%
% for-profit	70%	66%	51%	29%*
% public	8%	10%	10%	58%*
% voluntary	22%	24%	39%	13%*
Regulatory Staff				
Number	2,700	37	300	100
No. of nursing homes per regulator	4.9	4.4	1.9	8.2
No. of beds per regulator	537	622	320	284

* These figures refer to *all* institutions for the elderly in England.
Sources: The U.S. data is derived from tables in Institute of Medicine 1986; Harrington et al. 1985; and personal communications from relevant agencies. The English data are derived from Larder, Day, and Klein 1986, and Day and Larder 1986.

rely on informal social pressures to maintain internal discipline, cohesion, and consistency among agency staff, whereas New York has developed a highly sophisticated system of self-evaluation and statistical information as part of a continuing attempt to control its own officers.

New York, above all, is unique among our three cases for having developed its own methodology of regulation, and for the fact that this is outcome oriented (Axelrod and Sweeney 1984). The starting point for each facility inspection is a review of patients to identify "Sentinel Health Events" (SHEs). These are negative outcome indicators, i.e, conditions which, given good quality care, need explanation and justification. SHEs include contractures, decubitus ulcers, accidents, indwelling catheters, the use of restraints, and poor grooming. Patient observation is also emphasized (New York Office of Health Systems Management 1982). If the incidence of SHEs is above the statistical norm for facilities, there then follows a more detailed investigation of all relevant cases. This information, in turn, feeds into the conventional survey procedure, as does the information from the complaints system. The two forms of review are seen as complementary (Axelrod and Sweeney 1984, 2). The SHE process "is a review of the quality of care rendered to patients. It is patient-centered in that it evaluates quality from the vantage point of the individual patient's experience in a facility, as opposed to the survey which measures the facility's capability to render care and service." The history of this inspection methodology is, in itself, revealing of the New York style. First, the impetus to change came from public scandal and public pressure in the 1970s. Second, the methodology was developed on the basis of a special study carried out by an academic institution. Third, it was introduced only after field trials and prolonged staff training sessions. Fourth, it involved the creation of a new data processing system. Fifth, it has been subjected to a detailed evaluation (New York Office of Health Systems Management 1982). In this it illustrates the highly professional, self-critical, and intellectually sophisticated New York approach to regulation, as well as perhaps a general regulatory paradox. This is that the greater the risk of *unavoidable* public scandals, the greater will be the care taken by the regulators to demonstrate their own organizational and technical competence and integrity.

New York's outcome-centered methodology of regulation has been stressed because, in other respects, the formal regulatory requirements in our three case studies provide few surprises. They largely follow the national models outlined in the previous section, with variations

in emphasis rather than of principle, the variations following the by now predictable pattern of New York and England at the two poles, with Virginia in the middle. So, for example, New York's awesomely heavy tome of codes, rules, and regulations (New York 1983) contrasts with Virginia's slim volume setting out the state's licensure rules and regulations (Virginia 1980); the latter is not so very different from the notes of guidance published by the average English DHA. Again, the state requirements in New York tend to be more stringent, more numerous, and more precise than those in the federal code, whereas in Virginia the requirements generally follow the federal conditions, although allowing nursing homes licensed or under construction before 1980 to operate with lower physical standards. As against New York's 63-page SHE protocol, with its elaborate instructions to surveyors about how to collect the information and about sampling methodology, Virginia has a 3-page checklist for a "quality assurance walk through," which asks surveyors to observe, for example, whether the staff have a "happy/hurried/defensive communication with residents" and whether patients are "happy/glum, open/afraid to talk" and so on; a checklist which was promptly and enthusiastically adopted by the regulatory staff of an English DHA when shown to them by the authors.

In all these respects, Virginia tends to lean toward English practice, in the sense that its requirements are less stringent and its procedures less mechanistic than New York's. But, as might be expected from the discussion of national frameworks in the previous section, in two crucial respects Virginia is much closer to New York than it is to England. First, both Virginia and New York have patient-centered systems, predictably so given that one of the main concerns of the American regulatory system is to make sure that public money doesn't buy the wrong kind of care for the wrong type of patient at the wrong price. Although Virginia has nothing like New York's outcome-oriented system, it does have an extensive data system that provides information about all Medicaid patients (Virginia 1985) and is designed to ensure that patients do not get inappropriate institutional care where other forms of support might be better. In Britain, there is *no* system for collecting data about nursing home clients (Day and Klein 1987a). DHAs have no way of telling routinely how old the nursing home patients are, what their medical condition is, how their stay is being financed, or whether they are getting any form of treatment from anyone. DHA surveyors will look at the individual patients during their visits, and some have even begun to devise their

own homemade forms of assessment. But there is no standard assessment form which allows changes over time to be recorded.

Second, and again predictably, the regulatory guidelines of English DHAs differ from both New York's and Virginia's in their concentration on input, rather than process or outcome requirements. The emphasis, in line with the national model, is on specifying the size of rooms, laundry and catering facilities, the number of bathrooms and lavatories, and so on. The registration staff of each DHA also "lay down the number of registered nurses, enrolled nurses and nursing auxilliaries to be on duty at any time of the 24 hours" (Southport District Health Authority 1985); there are wide variations in staffing levels since these are fixed not in the guidelines but left for each nursing home to take account of its physical layout and patient mix (Day and Larder 1986). But there is not the assumption, reflected in both New York's and Virginia's process requirements, that producing treatment plans or activity programs for individual patients can be taken as an indicator of quality. Instead, the assumption implicit in DHA guidelines is that the appropriate institutional environment, as reflected in inputs or structure, will lead to quality of care "by creating an atmosphere which will promote individuality and personal preference in matters of daily living," and by ensuring that patients "live in comfortable, clean and safe surroundings" and are treated "with respect and sensitivity to their individual needs and abilities" (Oxfordshire District Health Authority 1985). In short, the state and DHA requirements accurately reflect the biases of the two national systems and their different perceptions of the function of a nursing home. To caricature only a little, in England the emphasis is predominantly on interpreting quality in terms of patient comfort and the atmosphere of the home; in the United States it is on seeing quality in terms of energetic (preferably medical or technical) intervention.

Models of Regulatory Enforcement

New York's exceptionalism is once again evident when we move to analyzing the models of enforcement in our three study areas. New York is the epitome of the hairs-on-chest, no-nonsense enforcement model in line with what might be expected from its adversarial political structure. It provides an example of a deterrence model of

enforcement, to return to the vocabulary of the general literature on regulation. In contrast, Virginia resembles England in relying on a compliance model. If Virginia's case is anything to go by, therefore, differences in political culture within countries appear to be more important than differences between nations when it comes to the enforcement of nursing home regulations; the neat Anglo-American antithesis turns out to be too simple by half. And even the New York model turns out to be blurred, its sharp edges blunted, in the day-to-day practice of regulation, as we shall see when we move on to the implementation of the enforcement models.

New York is quite explicit in adopting a deterrence model of enforcement. Interviews with the agency officials at the top of the organizational hierarchy produced a unanimous and emphatic insistence that "we are policemen, whose job it is to enforce the regulations. . . . There is no room for the nice consultant telling facilities how to do a good job." The role of the inspectors, as they saw it, was "to go in, define the problem, give a ticket to the nursing homes and expect them to put it right." It was not the job of the inspectorate, they stressed, to identify or even discuss solutions to the problems: "We go in to determine whether they are managing properly, not to manage it." The agency philosophy is that as long as the product is right, it is not the business of the inspectorates to tell the facility how to run itself: hence, of course, the insistence on measuring outcomes as a proxy for the quality of the product. Conversely, if the product is not right, it is the responsibility of the nursing home management to take the appropriate action: "We don't tell them how to correct problems." So, defects in outcomes are not related to inadequacies in inputs. Agency policy, for example, is not to prescribe staffing levels as a way of remedying inadequacies, partly because staffing levels in New York are traditionally generous, partly because of the implications for reimbursement rates. The formal, keep-your-distance approach is also evident in the way in which New York surveyors write their reports. Surveyors can only record a deficiency if it is in the code. So, for instance, nursing surveyors may think that wrong or inappropriate techniques are being used. But if there is no specific reference to this in the code, such judgments cannot be allowed into the survey deficiency reports. Hovering over every report writer is the specter of a lawyer who will challenge any deficiency report that is not sustained by the code. In summary, then, the New

York model is characterized by its outcome or product orientation, by its assumption of a hands-off and hostile relation between regulators and regulated, and by its emphasis on legal process.

If New York is an example of a state where a sophisticated regulatory bureaucracy polices what is seen as a potentially predatory industry, Virginia is an example of a state where a small regulatory team is involved in a complex social and political relationship with its nursing home industry. The tone of voice in the interviews with Virginia's regulators was not so different from that found when talking to regulators in English DHAs. In both cases, the emphasis was on drawing the industry into a cooperative partnership. The Virginian tone is nicely caught in the state's introductory notes of guidance to facilities with Medicaid patients: "The goal of Virginia's Medical Assistance Program is to provide medical care for Virginia's needy citizens. You, the provider, play an important part in the success or failure of the Program to achieve this goal. . . . On behalf of the Citizens of the Commonwealth your participation is greatly appreciated" (Virginia 1982). Similarly, the notes of guidance devised by the English DHAs are addressed to nursing home proprietors and, in particular, to newcomers to the industry. They are designed to be helpful to prospective proprietors, some of whom know little about nursing homes, as well as setting out the formal rules and regulations.

Virginia, like England, offers an example of the compliance model in action. Within the relatively small regulatory agency itself, control is largely a matter of informal relations among the people working in it. Similarly, there is a deliberate emphasis on building up trust relationships with the facilities, with no apparent sense that this may risk regulatory capture by the industry. In the words of one member of the agency staff, "We see ourselves as part of a team rather than just merely as enforcers." Teams of surveyors are kept together for three or four years so that they can "build up good working relationships" with nursing homes. If there are real worries about conditions in a nursing home, the survey team may make repeat visits and give advice: "We become resource persons." The close relations with providers do not exclude unannounced surprise visits, sometimes at night. But they do set up the expectation that the provider will comply voluntarily by producing a plan of correction, that argument and advice will be the main weapons of enforcement and that legal processes will be involved very rarely. In summary, the reliance is on persuasion rather

than the law, although there is an awareness that this strategy may be more effective in the traditional rural areas of the state than in the metropolitan belt around Washington, in particular. In all this, Virginia is as determined as New York to enforce its standards, but does so in a more relaxed style and with a clear idea of the need to restrict the activities and power of both government and business.

The DHA enforcement model in England is remarkably similar to Virginia's. If anything, it is even more informal because of the small and scattered nature of the regulatory staff. This means that there is no distinct regulatory agency and, therefore, no explicit regulatory philosophy. Most English regulators are nurses, and tend to see themselves as professional colleagues of the nurses in charge of homes. They perceive their role as being largely to improve professional practices, such as the management of incontinent or demented patients, and to this end most of them organize study days and training sessions designed to bring nursing home staff into the mainstream of professional thinking about "good practices." They see themselves as providing support, education, and advice. The general assumption is that if things go wrong in a nursing home it is just as likely to be the result of ignorance, isolation, or incompetence as of predatory commercialism or deliberate exploitation. If a nursing home is in trouble the resulting series of visits by inspectors is therefore as likely to be designed to prop up staff morale and to improve care as to spot infractions of the rules. There are few inhibitions about demanding improvements in staffing. It is a model of enforcement which, as in Virginia, does not imply laxity of standards or tolerance of shortcomings but simply a different kind of diagnosis about why things go wrong—human frailty as much as human greed—and about what treatment is needed—from that implicit in New York's model.

The Virginian style is also reflected in the letters sent out to facilities after inspections of care. There is little sense of an invisible lawyer crouched over the surveyor's shoulder, and the comments about inadequate treatment of patients are not limited to specific infractions of the codified rules and regulations as in New York. So, in one case, the agency points out (in a 6-page letter detailing deficiencies) that "residents were observed clad only in their night clothes without underwear, bath robes or lap robes" and that one patient, 4′ 2″ tall, was in a regular height bed with no step stool provided to assist her getting into bed, though she was reported to have "falls" and

that "four residents needed shampoos or hair care." As in New York, the formal assumption is that it is not the agency's role in these cases to suggest how such deficiencies should be put right or to specify, for example, what the staffing levels should be, no doubt for very much the same reasons: i.e., lest such instructions be used to justify extra financial claims. But, as we shall see when we turn to the style of implementation, the formal model is not always carried through into practice in either New York or Virginia. Nor, for that matter, is it in England. There, as noted, the emphasis of the formal regulatory approach is on institutions rather than on individual patients, on inputs rather than processes, let alone outcomes. Yet, as in Virginia, the letters that are sent out after inspections frequently make general remarks about individual patients or the environment in which they live. So they will, for example, note "that an elderly lady sitting in the garden was not provided with a blanket despite a request that this should be done" or that "there was a distinct smell of urine in parts of the home." In short, the convergence in the comments of surveyors provides a strong hint that, whether they are working in England or Virginia, they are reacting much the same way to much the same phenomena. And if this is so, does this further suggest that, whatever the formal differences between the models of regulation used, there may be a more general convergence in the way in which they are implemented in the two countries—even in New York? This is the question addressed in the next section.

Implementation of Regulation in the Field

There are a number of reasons for not taking regulatory models at face value as guides to what actually happens in the field. Whatever the agency philosophies, codes, and strategies, these still have to be translated into practice in a series of day-to-day encounters between the regulators and the regulated. This raises more than the general problem of street-level bureaucracy (Lipsky 1980), i.e., the difficulty in *any* organization of getting its field staff to implement agency policy. There is also an inevitable tension between the objectives of the agency and the desires of the staff to carve out areas of autonomy for themselves where they can use their own discretion and apply their own skills. But such tensions will be particularly evident in

regulatory agencies in general (Bardach and Kagan 1982) and in those dealing with nursing home regulation in particular.

First, if all street-level bureaucrats tend to carve out areas of discretion for themselves, this is likely to be a particularly strong drive in the case of nursing home surveyors. Most of these see themselves as professionals in their own right. This is particularly so for the nurses who form the largest single group of surveyors in New York (120 out of 300) and the majority in Virginia and England, and the social workers who are strongly represented in Virginia especially. And if they see themselves as professionals, we would expect them to assert their own discretion and to insist on using their professional judgment. Second, given the characteristics of nursing homes, surveyors cannot avoid using their discretion. Things simply do not speak for themselves; they have to be interpreted. This is a problem, as we have seen, common to all regulatory agencies; even in the case of water pollution inspectors have to make judgments about when something should be treated as an unavoidable or at least a pardonable accident rather than a deliberate offense (Hawkins 1984). But in the case of nursing homes, which are about the management of often very difficult people rather than about the management of pipes and machinery, such judgments are obviously even more frequent and crucial. As with water pollution, too, the surveyor's moral judgment of the provider will play a part. As regulators everywhere are agreed, nursing homes are peculiarly volatile institutions, where a sudden change of staff may produce a radical alteration in the quality of care provided. Inevitably, therefore, surveyors have to interpret such a change. Is it the result of circumstances outside the control of the nursing home manager? Is he or she doing his or her best to put matters right? Or does the change reflect the provider's incompetence or preoccupation with cutting costs? Depending on the answer, different strategies are likely to be pursued.

Lastly, we would expect nursing home regulatory staff to be particularly ill at ease with, and subversive of, a deterrent model of regulation. Not only does such a model rob them, in theory, of opportunities for discretion and professional judgment; equally it deprives them of the job satisfaction involved in using this expertise to give advice. But nursing homes, quite apart from their volatility, are examples of institutions where one cannot always observe yet seek to control (Reiss 1984). Any system of collecting statistics and of inspection, however frequent and however reinforced by the investigation of com-

plaints, may be at odds with the rhythm of change within nursing homes. Therefore, whatever the model of regulation adopted by the agency as its official policy, it will be rational for individual inspectors to try to build up informal trust relations wth nursing homes (even though, once they have judged the provider to be a predator immune to persuasion or education, they may throw the book at him). For most of the time, and perhaps for most nursing homes, any regulatory system depends on self-regulation and on the social pressures, from agency staff and others, which compel such self-regulation.

For all these reasons, stemming partly from the nature of the regulatory task itself and partly from the special characteristics of nursing homes, we would therefore expect to find convergence in the way in which the different models in our three study areas are implemented. And this is precisely what we do find. Even the "hard case" of New York, with its explicitly adversarial, legalistic, and deterrence model of regulation, turns out in practice to adopt a style of implementation that is not nearly so different from that of Virginia or England as the differences in their official philosophies and codes would imply. In what follows, we rely on impressionistic data collected in the course of a short visit and cannot present anything like a complete picture of how the New York system works. But we can and do identify examples of policies and practices that are incompatible with the official model and that suggest that the pure deterrence model may, in fact, be unimplementable whether in New York or anywhere else.

New York, as we have seen, is the epitome of a no-nonsense deterrence model based on a sophisticated technology of regulation. It is not only an agency that prides itself on explicitly repudiating the consultancy, advisory compliance model. It is also an agency that has developed a technology for measuring the achievement or otherwise of the required standards, i.e., its system of outcome indicators. The two are, of course, linked. If there are hard indicators of outcome, and if the provider's failure can be deduced from such measures, then there is no need to engage in negotiation about the meaning of what is going on in nursing homes or of bargaining about how, where necessary, to put things right. In an ideal deterrence model the facts and statistics do speak for themselves, yielding automatic verdicts and penalties; they deter precisely because they do not allow argument or excuses. There will, therefore, be a constant drive, as in New York,

to develop an ever more sophisticated technology of measuring what goes on in nursing homes in order to avoid argument about its interpretation and to stop excuses. Such techniques, it is argued, are a way of overcoming the problems of discretion, subjectivity, bargaining, and political judgment; there is actually a technological fix for our problems, and even the difficulties of implementation can be overcome by devising what in effect is a self-steering system.

But can they? The experience of New York suggests otherwise. As already argued, one of the characteristics of the New York agency is the energy applied to internal self-regulation. And one of the reasons for this is its acknowledged difficulty in preventing its field staff from playing a consultancy role. "We have continuously to remind them that they shouldn't be consultants," one agency officer pointed out. So one of the objectives of the New York training program for surveyors is precisely to prevent such recidivism. Even in the view of the nursing home industry itself, however, neither agency directives nor training fully succeed in this aim. In the words of one nursing home manager, "The relationship is 60% consultative, 40% a police approach. If we were in a strict police relationship, surveyors could close down 95% of the nursing homes in New York. The regulations are so complex that you could find nit-picking reasons for closing down just about every institution in the state." It was the same nursing home manager who pointed out that, contrary to the official view, plans of correction were usually worked out in negotiations with the agency staff: "We would know just through interactions with survey people what they want, even if they didn't put it on paper. There is lots of informal bargaining about plans of correction and scope for arguing about how best to put something right."

Similarly, New York is far more flexible in its use of penalties for infractions than a deterrence model would suggest. The state has an elaborate tariff system for calculating fines for different categories of violations (New York 1983, section 742.1), ranging from 100 to 1,000 dollars a day. But the tickets are not handed out automatically; nor are the fines, once imposed, collected automatically. In 1984, for example, a total of $549,000 in fines was imposed. But only $331,000 was collected. As the state agency officials explained, the use of fines and other penalties is part of a finely graded enforcement strategy. Just as fines are preferred to imposing sanctions such as a ban on admissions, let alone closing down facilities, so fines in turn are seen

as a form of suspended sentence designed to improve behavior: "Our preference is to get *compliance* [emphasis added] rather than to fine." Moreover, in deciding when and what sanctions to impose, moral judgments are made: "Enforcement is used on those facilities which historically have not conformed, and have got a pattern of infractions, or where conditions are so horrific that something must be done quickly." What is more, enforcement is inescapably a matter of political judgment in New York as elsewhere. It involves a judgment about the tradeoffs between encouraging a surplus of nursing homes (which makes deterrent measures such as closures easier) and the financial costs of so doing (New York's virtual ban on new developments is certainly a factor in inhibiting enforcement). It involves judgments, too, about the likely reactions in the community and by trade unions to threats of closures; inevitably so, given that nursing homes are a source of benefits not just to their ostensible clients, the patients (if indeed they are), but to their employees and to the community where they generate economic activity. In summary, enforcement—like inspection—cannot be seen as a mechanical process, where the trick is to choose the right instruments and design the appropriate machinery, but as a social and political process.

Lastly, it is clear that even the technological centerpiece of the New York regulatory system, the Sentinel Health Event (SHE) system for measuring negative outcomes, does not eliminate the need for discretion and professional judgment. The model of regulation implicit in the SHE system, as enshrined in official agency philosophy, is that if outcomes are satisfactory, there is no need to worry about either inputs or processes. There is no need, for example, to worry about staffing levels, the constant preoccupation of regulators in England. If care is delivered by a team of robots but outcome indicators are satisfactory, no matter. In fact, however, the actual use of the SHE instrument suggests a rather more complicated and less mechanistic pattern of behavior. For SHEs are only outcome *indicators*. They do not purport to measure actual outcomes. They simply send up signals that things are happening which should not be happening in well-run establishments. In other words, they are ways of alerting surveyors to start looking at inputs and processes in those institutions which have been identified as being at risk. They are a device, and were intended as such, for concentrating agency resources where there is most cause for concern. They do not dispose of the need for taking

an interest in inputs or processes, nor for the need for professional judgments by the inspectors.

Indeed, the inspectors interviewed, whether in New York, Virginia, or England, showed a remarkable consistency in the way they described their actual methods of inspection, irrespective of the official model of regulation. Often they used the same words to describe a process of quickly summing up the general atmosphere and smell of a nursing home before getting down to the specific regulatory requirements demanded of them by federal, state, or DHA codes and guidelines. And the reason they did so was because most of them were nurses, and spoke as nurses trained to observe the same things. If political cultures pull regulatory models in different directions, professional culture pulls regulatory practice together again.

In any case, an inspection visit is a complex social event which may not fit into the tidy categories of a regulatory model. For example, a model of regulation based on specific codes and precise instruments assumes that an inspection is like a scientific expedition, and that the main requirement is to provide the appropriate tools of investigation. But the reality of regulation is of a group of surveyors arriving in an untidy situation where they rely on their personal and professional sensors to pick up cues and hints which may signal deeper discontents. In short, we need a different model of knowledge (Lindblom and Cohen 1979) to explain what surveyors actually do, one which acknowledges tacit and experiential knowledge.

Again, the official models in Virginia and England are based, as we have noted, on observing, respectively, process and inputs. In practice, the distinction breaks down. Is the lack of a blanket for an elderly patient a deficiency in inputs (not enough provided by the facility) or in process (callousness on the part of staff) or in outcome (all patients should be warm)? The surveyor, and it is usually a female nurse in all of our three study areas, who enters a facility and immediately sniffs the air and looks at whether patients are sitting comfortably, is taking in all three dimensions of quality. She is searching for hints and signals, not for evidence that will stand up in a court. The latter will come at a subsequent stage in the inspection. If the signals are unfavorable, no matter whether they are prompted by a sophisticated statistical analysis as in New York or by a visual and olfactory trawl, the systematic check follows. And, it is tempting to conclude from this, the real difference in the three systems lies not so much in *what*

the inspectors are concerned about but *how* they rationalize and record their concerns. In New York, and in Virginia to a lesser extent, the nature of the regulatory system compels a detailed classification and detailed justification of their findings in terms laid down by a detailed legal code; not surprisingly so in a country with a written constitution, which emphasizes due process and legal justification. In contrast, in England, there is no such framework compelling inspectors to systematize their findings; again, not surprisingly so, in a country without a legal constitution, no tradition of legal redress against the executive, and with a small-scale system of nursing homes.

In tracing through national regulatory models to the front line of implementation, we have ended up with a more complex, finely shaded picture than that covered by the conventional antitheses between deterrence and compliance, legal and informal, American and British approaches to regulation. The evidence suggests that while the varying characteristics of the political and social environment tend to drive the models of nursing home regulation apart, with each nation or state imposing its own distinctive stamp on the system, the characteristics of the nursing home industry as well as shared problems in the regulatory task itself tend to bring them together again during the process of implementation. So while there is divergence in the formal regulatory models, there is often convergence in the methods used. A top-down analysis of national policies tends to stress the former; a bottom-up analysis of what happens at the front line tends to bring out the importance of the latter. The convergence is, of course, not complete. New York remains different in many respects, such as the degree of involvement by the courts; perhaps it could not be otherwise, given the scale of its regulatory activities, which dictates a degree of bureaucratic formalism absent in both Virginia and England. There were also indications that regulatory practices are more relaxed and informal in up-state as against down-state New York, providing a reminder that the characteristics of the nursing home industry are themselves not a fixed factor but may vary both within and between states and countries in some respects. The degree of convergence found does suggest, however, that, to return to the question we set ourselves at the start of this article, there are indeed problems and issues cutting across countries and states, stemming from the nature of nursing homes everywhere, which must be tackled by all regulatory systems.

Finally, our analysis suggests that it is important to distinguish

between two related but distinct dimensions of regulation. The first is concerned with the *techniques* of regulation, or the degree to which the definition of standards and the measurement of their achievement is developed. The second is concerned with *styles* of enforcement, or the familiar distinction between deterrence and compliance strategies. The two are linked, as we have seen. Reliance on sophisticated techniques goes hand in hand with a deterrence stance, as in New York. Less highly developed techniques go hand in hand with a compliance stance, as in Virginia and England. Nor is this surprising. The logic of developing sophisticated techniques is precisely to limit, as we have seen, surveyor discretion by a system of automatic signaling followed by the automatic imposition of penalties. The emphasis is on quantification, bureaucratic rules, and legal processes. Conversely, if techniques are less highly developed, more reliance will inevitably be put on the judgment and observations of surveyors. The emphasis is on the social processes between the regulators and the regulated, and their shared social environment. In our concluding discussion of the policy implications of our findings, we shall, therefore, distinguish between the *technological* and the *social-interaction* models of regulation in an attempt to capture both these dimensions. This seems a more satisfactory, because more comprehensive, way of distinguishing between regulatory models than the conventional but more limited distinction between deterrence and compliance strategies that draws attention only to enforcement styles.

Some Implications for Policy

Our finding that the actual, day-to-day process of nursing home regulation tends to converge, despite differences in national context, methods of finance, and regulatory philosophies, can yield a variety of policy conclusions. So one possible implication might be that the technological model needs to be further developed; if it does not work quite as expected, this might be because it is still too crude a piece of machinery. An alternative view might be that the social-interaction model, since descriptively it seems to capture reality rather well, should provide the basis for policy prescription and future developments. And yet a third conclusion might be that regulatory strategies should seek to combine aspects of both models. In what follows, we explore

the implications of pursuing these lines of argument. Since there is no systematic documentation of comparative standards in nursing homes in our three study areas or anywhere else, our discussion must, inevitably, remain tentative. And even if we did know more about comparative standards, this would not necessarily tell us anything about the impact of the regulatory systems as distinct from that of the environments in which nursing homes operate and of the methods used to finance them. Lastly, it might be argued that the problem of achieving desirable standards is not one of devising and operating an improved machinery of regulation but, in England as in the United States, one of inadequate finance; given the failure of successive studies, however, to find a consistent relation between inputs and outputs in nursing home care, it is unrealistic to assume that ploughing in more resources would make debate about the regulation of quality redundant. We shall, in any case, limit our own analysis to those issues which apply whatever the level of payments and whatever the system of finance; our exclusive concern, as we stressed at the beginning, is with the regulation of quality, as distinct from quantity or price.

Let us start with the case for developing the technological model of regulation. This rests on two crucial assumptions. It implies, first, that good care is something that can be defined and measured over time, and, second, that its production can be guaranteed given competent management. Like the medical model of care, it incorporates a belief in scientific method: in definable techniques and procedures leading to desirable (and measurable) outcomes. But on both counts there are reasons for skepticism at the very least, about the scope for applying the technological model to the regulation of the particular circumstances of nursing homes (just as there may be skepticism about applying the medical model to nursing home care). First, defining quality and measuring its achievements has inherent problems, both technical and conceptual. Clearly, as everyone agrees (Institute of Medicine 1986), the ideal technical instrument of regulation would be routine measures of outcome reliable enough to speak for themselves and to allow no argument; New York's SHEs are, after all, only indicators based on negative outcomes and merely represent a first step. If only this technical problem could be cracked, it may be argued, the technological model would surely work. However, and again there is general agreement in the literature, taking the first step is going to be very difficult (Challis 1981; Hawes 1983; Kurowski and Shaughnessy 1985). Equally,

we would argue, even the most technically sophisticated measures of outcome are never going to speak for themselves without ambiguity and without debate—i.e., that quality of care will never be automatically deducible from outcome measurements. Not only is the notion of quality itself contestable, in that it is liable to change over time and that it is culture-specific. More important still, most desirable outcomes are, in fact, continuing processes, crucially so for those nursing home patients (the majority) who are there to die. For these patients the way they are treated on their way to the grave—with kindness, courtesy, and consideration—will always be more important than whether or not they arrive there a little fitter or later. This is why a system of regulation which assumes, like the American one, that patients in nursing homes, like patients in hospitals, are there to be made well may lead to perverse results.

The other reason why the technological model of regulation is flawed and why its principles will inevitably be betrayed by practice, as we found, derives from the assumption that the right techniques of providing care will assure the right results. This is to ignore the basic dynamics of nursing homes as institutions which can create intolerable situations both for their patients and for their staff. To quote Vladeck (1980, 29):

> The typical nursing home is a pretty awful place. It is a pretty awful place *even when* it is clean and well-lighted, staffed to minimally adequate levels, and provides decent food, adequate medical attention, and a full slate of activities. It is awful because the circumstances, medical and social, of the people living there are extremely difficult to do much about, and because the presence of an adequate supply of individuals motivated, educated, and trained to work effectively in such circumstances is extraordinarily rare.

Not only is looking after the elderly a difficult, sometimes appallingly demanding task. But it is also a task that is largely left to the least trained and worst paid members of staff, the nursing aides. To quote Vladeck again (1980, 20): "Few jobs in this society are worse than those of aides in nursing homes. . . . And it is generally a job without much gratification. Aides bear the brunt of nursing home residents' grievances. Few aides ever see any of their patients get better. Fewer still ever advance up the occupational hierarchy within the nursing

home." In other words, it is the marginal people in the labor market looking after the marginal people in society.

The problems of nursing homes stem, therefore, not from the way in which the United States industry is financed or structured (although these may be aggravating factors) but from the very nature of these institutional dynamics. Here the experience of England provides clinching evidence. Over the years there have been numerous cases of poor conditions and poor treatment in various institutions for the elderly and other vulnerable groups. But these problems are as likely to erupt in the public as in the private sector. So, for example, there has been a series of scandals about the quality of care provided in NHS long-stay hospitals (reviewed in Martin 1984), just as there continues to be cause for concern about the quality of care provided in inner-city residential homes for the elderly run by local authorities (Social Services Inspectorate 1985b; Clough 1987). The crucial factor, then, is not the for-profit motive; staff, even in publicly owned institutions, may well pursue their own interests—maximizing their own autonomy, rather than profit—to the detriment of patients. It is that providing institutional care is inherently difficult and precarious. And it is precisely because of these characteristics of institutional care for the elderly that the technological model of regulation invariably proves impossible to sustain in practice. If maintaining good quality care (however defined or measured) is a continuous battle, in which defeats are inevitable and occasional scandals all too likely, then regulation in turn must be a continuous process.

The strength of the social-interaction model of regulation precisely is that it accurately reflects the facts of institutional life. If constant scrutiny is required, if the process of maintaining or improving quality is a continuing battle in which the regulators seek to make allies of the regulated, then this cannot be achieved by improving the techniques of regulation alone. If the social-interaction model is to be used as the basis for policy prescription, however, as distinct from merely being used to provide an accurate description of what goes on in Virginia, England, and (to an extent) even in New York, then it is important to draw out the full implications. For what we are discussing here is not simply the interaction between the regulators and the regulated. We are also arguing that the quality of life in nursing homes is influenced as much by the social environment as by the tutelage of the regulatory agency, and that the trick in successful

control of standards may lie as much in getting this whole relationship right—as in improved regulatory strategies—in developing, as it were, an ecological approach to regulation. So, for example, if instability is one of the problems of nursing homes, if regulatory staff cannot hope to know what is happening on a day-to-day basis, then the appropriate solution may be to find ways of increasing the visibility of what goes on in nursing homes by exposing their activities to more eyes for more of the time. This indeed is already more common practice in the United States than in England and is endorsed in the Committee on Nursing Home Regulation recommendations (Institute of Medicine 1986, chapter 6) for promoting consumer involvement in, and generating more information about, the activities of nursing homes; interestingly, however, this strategy is dealt with in one chapter while three chapters are devoted to proposals for improving the technology of regulation.

The logic of pursuing the full implications of the social-interaction model, of adopting what we have called an ecological strategy, suggests asking a series of even wider questions. For instance, we have stressed the inherent problem posed by working conditions in institutions, the sheer awfulness at times of looking after demented or dying elderly, and the consequent difficulties of attracting and keeping appropriate staff. There are a variety of possible responses. One may be, as in Virginia, to insist on training for unskilled staff; alternatively, reimbursement schedules could be changed in order to enhance pay and status. But yet another option could be to look at the balance between a given community and its nursing homes, to ask how many beds can actually be adequately staffed given the nature of the local labor market. Similarly, it might be sensible to ask what institutional size, combined with what kind of institutional layout, is most compatible with providing good quality care. The questions cannot, of course, be divorced from the issue of how good quality care is defined. In England the objective is largely, as we have seen, to create a homelike atmosphere, an aim also echoed in Virginia; in turn, this has created a consensus among English regulators that it is difficult to provide an adequate quality of life in institutions with more than 30 to 40 beds. If the objective is to provide active interventionist care, then this will inevitably mean bigger institutions; however, it still raises the question of just how big these institutions can become before quality of life suffers. Again, it may be worth exploring the issue of what the appropriate scale of regulatory activity should be. Just as it

is possible to have agencies which are too small to develop regulatory expertise (as in many English DHAs), so there may be a point where large agencies become dysfunctional. Need regulation necessarily be a state function if this means, as in New York, the creation of a large, somewhat introspective, bureaucracy in order to deal with an enormous industry? If a social-interaction model of regulation like Virginia's or England's is reinforced by strong community and professional networks, if control is to be exercised through the visibility of nursing homes to the local population, then this obviously cannot be reproduced in a state which has to regulate twice as many beds as the other two put together. But it could be reproduced if regulation were devolved to lower and smaller tiers of government, although obviously there is a balance to be drawn between regulatory agencies which are overbureaucratic because overlarge and those which are overindulgent because they are not strong enough to resist local pressures.

Adopting the social-interaction model, and an ecological approach to regulation, also implies adopting a pluralist stance. The model suggests that the design of regulatory systems should match the social, political, and economic circumstances of their environment. What is appropriate in Virginia will not necessarily be appropriate in New York; what is appropriate in up-state New York will not necessarily be appropriate in the Bronx and Brooklyn. So divergences from the national norm, the wide spread in practices revealed by just about every survey of regulatory enforcement in the United States, need not necessarily be a sign of original sin, of deviations from some golden norm of good practice. Instead, the somewhat different way in which federal policies have been adapted in the implementation process can be seen as a learning process (Majone and Wildavsky 1978), in which the national framework is adapted to local circumstances. Conversely, this interpretation, if accepted, would suggest that the drive toward greater conformity in regulatory practices between states, the demand for ever tighter federal standards and more precise federal instruments of assessment, may be something of a search for technologist's gold.

To make this point is to bring the argument to our last option, which is to acknowledge that a working model of regulation will inevitably have to have a number of different dimensions. An effective system—that is, one which protects the individual patient as well as bringing the nursing home into line—must combine techniques *and* social interaction, relations with the community *and* the ecology of

the nursing home industry. For if the weakness of the pure technological model is that it cannot be implemented in practice, the weakness of the pure social-interaction model is that it can all too easily slide into relativism. Is adaptation to the local environment to be the only test of the effectiveness of a regulatory system? What differences in standards and enforcement procedures between states are tolerable? If a mechanical legalism is the occupational disease of a technological approach to regulation, sloppy subjectivism is the danger inherent in the social-interaction model; so, for example, in England there is a clear case for the development of techniques of measurement and the codification of some standards in order to discipline the judgment of surveyors (Day and Klein 1987a). Our analysis does not, therefore, dismiss the need for improving the techniques of regulation. Our argument, rather, is that these should be used as tools in the complex process of regulation, formal and informal. Techniques, such as outcome measures, may discipline subjective judgments, just as they feed into a wider social dialogue. But they cannot be a substitute for either; regulators going down that narrow path are likely to find themselves between a rock and a hard place. Nursing homes are society's means for putting the cloak of institutional invisibility around some of its most intractable and nasty problems, and if we treat them solely as a technical issue instead of arguing about them, we will create a more worrying situation than any yet uncovered.

References

Abel-Smith, B. 1964. *The Hospitals in England and Wales, 1800–1948.* Cambridge: Harvard University Press.

Ashford, D.E. 1978. *Comparing Public Policies.* Beverly Hills: Sage.

Audit Commission. 1986. *Making a Reality of Community Care.* London: Her Majesty's Stationery Office.

Axelrod, D., and R.D. Sweeney. 1984. *Report to the Governor and the Legislature on the New Surveillance Process for New York State Residential Health Care Facilities.* Albany: New York State Department of Health.

Bardach, E., and R.A. Kagan. 1982. *Going by the Book.* Philadelphia: Temple University Press.

Bartlett, H., and L. Challis. 1985. Private Nursing Homes for the Elderly: A Survey Conducted in the South of England. Bath:

Centre for the Analysis of Social Policy, University of Bath. (Mimeo.)

Bennett, J. 1986. Private Nursing Homes: Contributions to Long-stay Care of the Elderly in Brighton Health District. *British Medical Journal* 293:867–70.

Butler, P.A. 1979. Assuring the Quality of Care and Life in Nursing Homes: The Dilemma of Enforcement. *North Carolina Law Review* 57 (6):1317–82.

Challis, D.J. 1981. The Measurement of Outcome in Social Care of the Elderly. *Journal of Social Policy* 10 (2):179–208.

Clough, R. 1987. *Independent Review of Residential Care for the Elderly within the London Borough of Camden.* London: Borough of Camden.

Day, P., and R. Klein. 1985. Monitoring Standards in the Independent Sector of Health Care. *British Medical Journal* 290:1020–22.

———. 1987a. Quality of Institutional Care and the Elderly: Policy Issues and Options. *British Medical Journal* 294:384–87.

——— 1987b. Residential Care for the Elderly: A Billion-pound Experiment in Policy-making. *Public Money* 6 (4):19–24.

Day, P., and D. Larder. 1986. *Nursing Manpower in Private and Voluntary Nursing Homes for the Elderly.* Social Policy Paper no. 8. Bath: Centre for the Analysis of Social Policy.

Department of Health and Social Security. 1981. *Registration and Inspection of Private Nursing Homes and Mental Nursing Homes.* Circular no. HC (81) 8. London.

———. 1985. *Review of the Costs Incurred by Health Authorities in the Registration and Inspection of Private Nursing Homes and Hospitals.* Report no. 10/85 of the NHS Management Service. London.

Donabedian, A. 1966. Evaluating the Quality of Medical Care. *Milbank Memorial Fund Quarterly* 44:166–206.

Fox, D.M. 1986. *Health Policies, Health Politics.* Princeton: Princeton University Press.

Harrington, C., R.J. Newcomer, C.L. Estes, and Associates. 1985. *Long-term Care of the Elderly.* Beverly Hills: Sage.

Hawes, C. 1983. Quality Assurance in Long-term Care. A Briefing Paper for the National Academy of Sciences Institute of Medicine Committee on Nursing Home Regulation, Washington. (Mimeo.)

Hawkins, K. 1984. *Environment and Enforcement.* Oxford: Clarendon Press.

Hawkins, K., and J.M. Thomas. 1984. *Enforcing Regulation.* Boston: Kluwer-Nijhoff.

Health Advisory Service. 1986. *Report on Services for Elderly People Provided by the Brighton Health Authority and the Social Services Department of East Sussex County Council.* Sutton, Surrey.

House of Commons. 1926. *Report from the Select Committee on Nursing Homes (Registration).* HC 103. London: Her Majesty's Stationery Office.

Institute of Medicine. 1986. *Report of a Study by the Committee on Nursing Home Regulation.* Washington: National Academy Press.

Kagan, R.A., and J.T. Scholz. 1984. The Criminology of the Corporation and Regulatory Enforcement Strategies. In *Enforcing Regulation,* ed. K. Hawkins and J.M. Thomas, 67–95. Boston: Kluwer-Nijhoff.

Kelman, S. 1984. Enforcement of Occupational Safety and Health Regulations: A Comparison of Swedish and American Practices. In *Enforcing Regulation,* ed. K. Hawkins and J.M. Thomas, 97–119. Boston: Kluwer-Nijhoff.

King, A. 1973. Ideas, Institutions and the Policies of Governments: A Comparative Analysis. *British Journal of Political Science* 3 (3):291–313.

Klein, R. 1979. Ideology, Class and the National Health Service. *Journal of Health Politics, Policy and Law* 4 (3):464–90.

Kurowski, B.D., and P.W. Shaughnessy. 1985. The Measurement and Assurance of Quality. In *Long-term Care,* ed. R.J. Vogel and C.H. Palmer, 103–33. Aspen: Aspens Systems Corporation.

Larder, D., P. Day, and R. Klein. 1986. *Institutional Care for the Elderly: The Geographical Distribution of the Public/Private Mix in England.* Social Policy Paper no. 10. Bath: Centre for the Analysis of Social Policy.

Lindblom, C.E., and D.K. Cohen. 1979. *Usable Knowledge.* New Haven: Yale University Press.

Lipsky, M. 1980. *Street Level Bureaucracy.* New York: Russell Sage Foundation.

Majone, G., and A. Wildavsky. 1978. Implementation as Evaluation. In *Policy Studies Review Annual* 2:113–27. Beverly Hills: Sage.

Majone, G. 1982. Prevention and Health Standards: American, Soviet and European Models. *Journal of Health Politics, Policy and Law* 7 (3):629–48.

Marmor, T.E. 1983. *Political Analysis and American Medical Care.* Cambridge: Cambridge University Press.

Martin, J.P. 1984. *Hospitals in Trouble.* Oxford: Basil Blackwell.

McLachlan, G., and A. Maynard. 1982. *The Public/Private Mix for Health.* London: Nuffield Provincial Hospitals Trust.

Moran, M. 1986. Theories of Regulation and Changes in Regulation: The Case of Financial Markets. *Political Studies* 34 (2):185–202.

National Association of Health Authorities. 1985. *Registration and Inspection of Nursing Homes: A Handbook for Health Authorities.* Birmingham.

National Audit Office. 1985. *National Health Service: Control of Nursing Manpower.* London: Her Majesty's Stationery Office.

New York. 1983. *Official Compilation of Codes, Rules and Regulations. Title 10: Health. Vol. C.* Albany: Department of State.

New York Office of Health Systems Management. 1982. Facility Surveillance Group: PMR/IPR Manual. BLTCS-03. Albany. (Mimeo.)

Oxfordshire District Health Authority. 1985. *Registration and Conduct of Nursing Homes: Guidelines.* Oxford.

Patterson, S.C. 1968. The Political Cultures of the American States. *Journal of Politics* 30 (1):187–210.

Reiss, A.J. 1984. Selecting Strategies of Social Control over Organisational Life. In *Enforcing Regulation,* ed. K. Hawkins and J.M. Thomas, 23–35. Boston: Kluwer-Nijhoff.

Ruchlin, H.S. 1979. An Analysis of Regulatory Issues and Options in Long-term Care. In *Reform and Regulation in Long-term Care,* ed. V. Laporte and J. Rubin, 81–125. New York: Praeger.

Social Services Inspectorate. 1985a. *Inspection of Local Authority Care for Elderly Mentally Disordered People.* London: Department of Health and Social Security.

———. 1985b. *Inspection of Residential Care for Elderly People and for Children in the London Borough of Southwark.* London: Department of Health and Social Security.

Southport District Health Authority. 1985. *Notes of Guidance on the Registration and the Conduct of Nursing Homes.* Southport.

Statutory Instruments. 1984. *The Nursing Homes and Mental Nursing Homes Regulations.* Department of Health and Social Security SI no. 1578. London: Her Majesty's Stationery Office.

Torbay District Health Authority. 1985. *Strategic Development Study into Services for the Elderly.* Interim report. Torquay: Torbay Health Authority.

U.S. Congress. 1984. *Long-term Care in Western Europe and Canada: Implications for the United States.* An information paper prepared for use by the Special Committee on Aging, United States Senate, 98th Congress, 2nd Sess., S Prt 98–211 34–708. Washington.

———. 1986. Nursing Home Care: The Unfinished Agenda. Washington.

Virginia. 1980. *Rules and Regulations for the Licensure of Nursing Homes in Virginia.* Richmond: Department of Health.

———. 1982. *Nursing Home Manual.* Richmond: Virginia Department of Health.

———. 1985. *Virginia Medical Assistance Program Long-term Care In-*

formation and Monitoring System. Richmond: Department of Medical Assistance Services. (Mimeo.)

Vladeck, B.C. 1980. *Unloving Care: The Nursing Home Tragedy.* New York: Basic Books.

Vogel, D. 1983. Co-operative Regulation: Environmental Protection in Great Britain. *Public Interest* 72:88–106.

Waldman, S. 1985. A Legislative History of Nursing Home Care. In *Long-term Care: Perspective from Research and Demonstrations,* ed. R.J. Vogel and C.H. Palmer. Aspen: Aspen Systems Corporation.

Wilson, G.K. 1984. Social Regulation and Explanations of Regulatory Failure. *Political Studies* 32 (2):203–26.

Wilson, J.Q. 1980. ed. *The Politics of Regulation.* New York: Basic Books.

Woodruffe, C., and P. Townsend. 1961. *Nursing Homes in England and Wales: A Study of Public Responsibility.* London: National Corporation for the Care of Old People.

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