

# Privatization, System Membership, and Access to Home Health Care for the Elderly

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SINCE 1980, REIMBURSEMENT CHANGES, COST containment, deregulation, and technology have transformed the site and duration of health care. Among the contributors to this shift are enhanced competition, greater market share of for-profit providers, vertical and horizontal integration, and changes in Medicare payment. The rapidity and complexity of change have significantly affected health care access for the aged.

The home health agency (HHA) is an important bulwark of postacute care. Limits on Medicare coverage and on the ability of clients to pay out of pocket heighten the importance of HHA capacity and willingness to care for unprofitable clients. We will consider here how access relates to both HHA organization and local market factors. For example, market competition has been shown to affect the cost and other elements of care (Robinson and Luft 1987). Research on hospitals (Renn et al. 1985; Schlesinger et al. 1987) suggests that access to care has become more restricted and that access patterns may be explained by organizational and market factors (Swan and Estes 1990). Although there has not been much research on access to home health care, likely explanatory factors include tax status (for-profit versus nonprofit), organizational complex-

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ity (system member versus freestanding), and environmental conditions reflecting competition among HHAs.

## The Restructuring of Home Health

We focus on privatization and rationalization. Privatization involves expanded private-sector roles (Asher 1987; Weller and Manga 1983): increase in for-profits; decline of and other changes in nonprofits; and decline of public agencies (Berghold, Estes, and Villanueva 1990; Scalzi and Meyer 1992).

Rationalization involves the bureaucratization and increasing complexity of organizations, especially horizontal and vertical integration. The structural transformation of the home health industry is reflected in the growing numbers of, and the shift toward, multifacility systems and chains (Starr 1982), as seen in the increased number and proportion of HHAs based in hospitals, nursing homes, and other institutions. It also combines nonprofit and for-profit agencies in mixed forms, leading to more complex organizations.

Privatization and rationalization were stimulated by federal policies, such as deregulation, that allowed Medicare certification of for-profit HHAs without licensure (Estes et al. 1992). Entry of for-profits into the Medicare program dramatically transformed the market, causing for-profits to become the most numerous HHA type for the first time: by 1986 they comprised one-third of Medicare-certified HHAs, compared with one-fourth nonprofit, one-fifth government, and one-quarter hospital based (Waldo, Levit, and Lazenby 1986; Estes et al. 1992).

## Structural and Behavioral Factors in Health Care: Isomorphism

Research on behavioral variation by tax status has been stimulated not only by structural change, but also by developments in institutional and ecological schools of organizational sociology, especially their work on isomorphism (DiMaggio and Powell 1983), which examines the process whereby agencies facing similar conditions are forced or encouraged to resemble one another (Hawley 1968). Pressures to homogenize result from environmental uncertainty, change in law or policy, or cultural ex-

pectations. DiMaggio and Powell (1983) argue that responses to governmental and professional actions and competitive environments result in greater interaction among agencies; the emergence of sharply defined patterns of domination and coalition; increased information loads; and mutual awareness of being in a common enterprise (DiMaggio 1982).

Two classes of isomorphism are the competitive and the institutional, with the latter class containing three types: coercive, mimetic, and normative (DiMaggio and Powell 1983). Coercive isomorphism stems from cultural expectations and pressures from the government or other entities (e.g., parent corporations), experienced as force, persuasion, collusion, or legal/technical requirements. Mimetic isomorphism reflects a "standard response" to uncertainty: imitation of the legitimate or successful (DiMaggio and Powell 1983, 151). Normative isomorphism derives from professionalization: transmitting a field's educational and cognitive base and developing and operating professional networks. Formal caregivers look to reference groups for lessons and cues: thus, they supply an important cultural and normative dimension to organizational behavior.

Institutional isomorphic processes may proceed despite a lack of evidence that the resulting changes will achieve efficiency or other improved performance (DiMaggio and Powell 1983; Fligstein 1990). Competitive isomorphism, which emphasizes system rationality, market competition, and niche change, is here applied to local markets over a short period of time. Successful response to environmental conditions tends to be replicated throughout a population of agencies (Hannan and Freeman 1977).

All three institutional isomorphic processes operate in home health, which explains the homogeneity of HHA access. In a dynamic environment of competition, change, and uncertainty, mimicry may drive HHAs to imitate institutional styles viewed as successful, legitimate, or predominant (Estes, Binney, and Bergthold 1989). When privatization is ideologically strong and for-profits enjoy reputations for efficiency and competitive advantage, nonprofits may mimic for-profit structure and behavior; but if nonprofits predominate, for-profits may instead mimic them. Normative isomorphism may result when certification, critical staff shortages, and growing caregiver professionalization encourage diverse HHAs to adopt similar staffing patterns and strategies.

Payment and regulatory mechanisms discipline mission, structure, and behavior, resulting in links between organizations that decrease the

autonomy of some units in exchange for the advantages of joint action and resources, thereby reducing other loss of autonomy that might result from environmental dependence and uncertainty (Cook et al. 1983). The degree of coercion varies across a spectrum, ranging from ownership, through joint ventures and contracting, to informal agreements (Alexander and Morrisey 1989; Longest 1990). Links vary in freedom of entry (Longest 1990), but all involve ceding autonomy; and even low-structure, freely entered links carry pressures to conform to dominant or influential models.

Coercive systems also restrain nonprofits from acting like for-profits, however (Clarke and Estes 1991). Even when pressures on for-profits and nonprofits are similar, factors like mission statements and ideologies of boards of directors may push nonprofits into a different response: for example, they may be constrained to handle excess demand through waiting lists, whereas for-profits are freer to employ pricing structure (Weisbrod 1988). Weisbrod's government-failure theory argues that nonprofits are expected to fill the gaps left unfilled by government, while their ability to do so is constrained by their tax status.

Although simultaneously operating factors can promote both isomorphism and differentiation, strong isomorphic processes push the boundaries of HHAs toward the limits allowed by coercive structures: ideologies of business efficiency substitute for service to community; regulators, payors, and legislators enforce adoption of for-profit practices to the limit allowed by law; professional standards consonant with for-profit practice dominate; nonprofits mimic for-profits, and vice versa, within bounds allowed by tax codes. At the extreme, a nonprofit's tax status is changed to create a for-profit. Thus, isomorphic processes erode the structures that differentiate nonprofit from for-profit HHAs.

If mimetic, normative, and coercive forms of isomorphism induce different responses, relative strengths of different isomorphic forms can be tested. Within coercive structures (e.g., chain membership), coercive isomorphism suggests a more monolithic response than that of mimetic isomorphism, whereas mimicry has a uniform nature, cutting across such structures. Normative isomorphism may be stronger in certain areas (e.g., patient care), weaker in others (e.g., reimbursement). Competitive isomorphism derives from environmental rather than organizational factors. Insofar as agencies in an area are induced by their environment to act in similar ways, they may be less differentiated by organization-specific fac-

tors; the actions of for-profits and nonprofits may converge under certain environmental conditions.

### Research on Access to Care by Privatization and Rationalization

Although both for-profit and nonprofit hospitals select patients so as to avoid unprofitable care and to dump the uninsured on public providers (Gray 1986), some find other tax-status variation among hospitals in uncompensated care, with nonprofit hospitals providing more care than for-profits to low-income uninsured (Lewin, Eckles, and Miller 1988). Marmor, Schlesinger, and Smithey (1987) note that for-profits are more likely to engage in patient selection or other methods to avoid unprofitable care. For-profits may avoid low-income and attract high-income patients by relocating (Bays 1983; Homer, Bradham, and Rushefsky 1984; Schlesinger et al. 1987); not providing unprofitable services, no matter how cost effective (Nutter 1984) or beneficial (Kaluzny et al. 1970; Cromwell and Kanak 1982; Shortell et al. 1986; Schlesinger et al. 1987); screening out or discouraging admission of persons unable to pay (Marmor, Schlesinger, and Smithey 1987); and being unresponsive to the need for sliding scales and uncompensated care (Gray 1986; Schlesinger and Dorwart 1984; Schlesinger 1986; Sloan, Valvona, and Mullner 1986; Schlesinger et al. 1987; Lewin, Eckles, and Miller 1988).

Research suggests that system members are more able than nonmembers to subsidize unprofitable services (Vladeck 1981; Brown 1982) and to acquire capital and subsidize unprofitable locations based on profitability elsewhere (Coyne 1982; Cohodes and Kinkhead 1984; Ermann and Gabel 1984; Schlesinger et al. 1987). System members may be less affected by local concerns, such as the need to provide charity care (Starkweather 1971; Ermann and Gabel 1984; Schlesinger et al. 1987), and more attuned to financial incentives (Mullner and Hadley 1984; Ermann and Gabel 1984).

Coercive and normative isomorphism can operate simultaneously, and mimetic isomorphism may be stronger, within systems, suggesting that isomorphism will push nonprofits to resemble for-profits in systems. Taken together, these processes should lead to convergence of for-profits regardless of system membership and of both for-profit and nonprofit system members.

Researchers' intensified interest in the processes of isomorphism, the ambiguity of earlier findings, and the speed and degree of health industry change offer an opportunity to test theory on a health care issue of increasing salience: access to posthospital home health care.

## The Research Problem

Our analysis addresses an important issue in services for the aged: access to home health care. We considers the effects on home health access of tax status (nonprofit or for-profit); organizational integration (system or free standing); environmental competitiveness (volume and market concentration of HHAs); substitute care (nursing-home beds per aged population); demand (percentage of the population that is aged); and state policy (home health certificate of need [CON]).

## The Study

Data were collected in a 1984–87 study of the effects of the prospective payment system (PPS) on community-based care: clients, services, staff, structure, and budgets of six types of community providers. The HHA sample consisted of 185 HHAs randomly selected from nine metropolitan areas in five states: San Francisco–Oakland and San Diego, California; Dallas–Fort Worth and Houston, Texas; Philadelphia and Pittsburgh, Pennsylvania; Seattle, Washington; and Tampa–St. Petersburg, Florida. Respondent HHAs were selected randomly by metropolitan area from frames comprising all HHAs on provider lists supplied by state licensing and certification agencies in the five study states, county lists, and relevant state and local trade association lists. Data from HHA directors, or their designated representatives, were collected during two 45-minute telephone surveys conducted 18 months apart, in 1986 and 1987, that achieved response rates of 92 percent in the first year and 89 percent in the second. Validity and reliability data checks assured consistency and accuracy from one year to the next. Because there are only nine public agencies, they were excluded from analysis, so privatization can be considered just in terms of access to nonprofit versus for-profit institutions, and not to public versus nonpublic facilities.

Health care access involves “those dimensions which describe the potential and actual entry of a given population to the health care system” (Anderson et al. 1983). Two themes affecting access are population characteristics and the delivery system (Anderson et al. 1983).

Access measures derive from items addressing various behavioral dimensions of access to services: agency policies, refusals to serve clients, and other procedures and characteristics of operation. This is not a study of service use patterns (i.e., objective measures of realized access, indicated by volume of services consumed relative to need). Rather, it provides behavioral and perceptual data on the likelihood that HHAs limit or refuse to provide services to particular types of clients or under particular conditions. The four access measures used here are reports of the following:

1. increases in fees or copayments
2. tightening of eligibility for services
3. refusals to serve some types of clients
4. refusals for financial reasons

Data collection occurred during a time of great change and growth in the home health industry. Our findings do not reflect the effects of subsequent important changes: massive continued growth in expenditures, the short-lived Catastrophic Health Care Act, and the implementation of resource-based relative value scale reimbursement for physicians.

## Hypotheses

Environmental and organizational characteristics should predict reported HHA access. Table 1 summarizes the hypotheses, which refer to both original and changed behaviors. The effect of 1984–86 on 1986–87 service refusals for payment reasons is positive because earlier refusals should partially explain later refusals. The inclusion of the 1984–86 measure in the equation for the model makes it a change model.

The Herfindahl index measures market concentration, computed in terms of HHA market shares of area clientele. Number of HHAs per population measures competition and affects interpretation of the Herfindahl: high Herfindahl values mean uneven market share, in which

TABLE 1  
Home Health Agency Access Hypotheses

| Independent variables                             | Increased fees | Tight eligibility | Service refusal | Change in service refusal |
|---|----------------|-------------------|-----------------|---------------------------|
| Prior refusals                                    |                |                   |                 | (+) <sup>a,b</sup>        |
| Environmental measures                            |                |                   |                 |                           |
| SMSA Herfindahl index                             | - <sup>c</sup> | -                 | -               | 0 <sup>d</sup>            |
| HHAS per population                               | -              | -                 | -               | 0                         |
| State HH CON                                      | +              | 0                 | +               | +                         |
| Percent of population aged 65+                    | +              | +                 | +               | +                         |
| NH beds per population                            | -              | -                 | -               | 0                         |
| Organizational measures                           |                |                   |                 |                           |
| Agency part of chain/MFS                          | +              | +                 | +               | +                         |
| HHA is for-profit                                 | +              | +                 | +               | +                         |
| Interaction of for-profit with chain/MFS member   | (-)            | (-)               | (-)             | (-)                       |
| Interaction of for-profit with Herfindahl index   | (-)            | (-)               | (-)             | (-)                       |
| Interaction of for-profit with SMSA HHA imbalance | (-)            | (-)               | (-)             | (-)                       |

<sup>a</sup> + Hypothesis of positive relationship.

<sup>b</sup> ( ) Hypothesis of sign opposite that for for-profit.

<sup>c</sup> - Hypothesis of negative relationship.

<sup>d</sup> 0 No hypothesis as to direction of relationship.

*Abbreviations:* HHA, home health agency; HH CON, home health certificate of need; MFS, multifacility system; NH, nursing home; SMSA, standard metropolitan statistical area.

most HHAs are competing with larger HHAs. High values of both measures represent conditions in which it is hypothesized that many HHAs admit whatever clientele they can. State home health CON regulation erects market-entry barriers that reduce competition; thus, the impact of CON is opposite that of number of HHAs. CON does more than limit competition, however, because it also represents the planning required of HHAs in order to justify their actions, leaving them less free to tighten eligibility; thus, this access measure has no directional hypothesis. When demand is higher (a larger population of aged persons, fewer nursing-home beds), HHAs are freer to raise access barriers.



System-member (chain or multifacility system) HHAs are hypothesized to be better able to increase fees, tighten eligibility, and refuse services. For-profit HHAs are hypothesized to be less likely to offer services for high-need clients, but better able to compete in targeted service areas and thus more likely to increase fees, tighten eligibility, and refuse services. For nonprofits that are independent, free-standing HHAs, the traditions of nonprofit provision are more likely to remain intact; they are hypothesized to be less likely than for-profit HHAs to refuse services to persons who need them, even those who find it difficult to pay for these services. In accord with the theory of institutional isomorphism, we predicted that nonprofit-system-affiliated HHAs will behave like for-profit HHAs, that is, they will increase fees and copayments and refuse services. If there is organizational isomorphism, nonprofit-for-profit differences will be nonexistent or smaller among HHAs in systems than among free-standing HHAs. Hence, independent HHAs should be less likely to increase fees, tighten eligibility, and refuse services.

The competitive-isomorphism argument is that environment induces divergent HHAs to act similarly. With greater market concentration, for-profits and nonprofits should operate similarly. Thus, when an interaction between the Herfindahl index and for-profit status is part of the equation, it should have a sign opposite that denoting for-profit status in order to show less tax-status difference at higher concentration. Another interpretation hypothesizes the same findings, arguing that with higher concentration, for-profits are induced to accept less profitable clients, thereby increasing access, whereas nonprofits find it more difficult to subsidize unprofitable clients, and so reduce access, leading to convergence in the behavior of nonprofits and for-profits. HHAs may also mimic dominant agency types whose behavior becomes more homogeneous wherever either nonprofit or for-profit HHAs predominate ("agency imbalance").

## Findings

Table 2 gives means and standard deviations for major variables. Table 3 presents data on service refusals in which tax status is crossed by system membership. HHA directors were asked, "What types of clients referred to you, if any, cannot be served by your agency?"; responses were coded according to whether they referred to payment/reimbursement issues.

TABLE 2  
Home Health Telephone Survey Variables and Metropolitan Area Measures<sup>a</sup>

| Measures                                       | Mean                         | s.d.    | N     |
|--|------------------------------|---------|-------|
| SMSA Herfindahl index                          | 0.063                        | 0.024   | 166   |
| HHAs per 1,000 population                      | 1.90                         | 0.53    | 166   |
| Percent of population aged 65 or over          | 12.14                        | 4.04    | 166   |
| NH beds per 1,000 population                   | 47.73                        | 11.87   | 166   |
|  | "Yes" responses <sup>a</sup> |         |       |
|  | Number                       | Percent | Total |
| State has CON for home health                  | 48                           | 28.7    | 166   |
| 1986—agency tightened eligibility <sup>b</sup> | 99                           | 60.3    | 164   |
| 1986—agency increased fees/copay <sup>c</sup>  | 100                          | 63.2    | 159   |
| 1986—agency refused services <sup>d</sup>      | 118                          | 72.0    | 164   |
| 1987—agency refused services <sup>e</sup>      | 83                           | 58.7    | 148   |
| 1986—refusals, payment reasons <sup>f</sup>    | 101                          | 62.2    | 162   |
| 1987—refusals, payment reasons                 | 40                           | 28.4    | 146   |

<sup>a</sup> Weighted for numbers of agency clients.

<sup>b</sup> Home Health Survey item, 1986: "Since January 1984, has your agency done any of the following? Tightened eligibility?"

<sup>c</sup> Item, 1986: "Since January 1984, has your agency done any of the following? Increased fees or co-payments?"

<sup>d</sup> Item, 1986: "Since January 1984, has your agency done any of the following? Had to refuse service entirely to some types of clients?"

<sup>e</sup> Item, 1987: "Has your agency had to refuse services entirely to some types of clients?" [Previous items had specified "in the past 12 months".]

<sup>f</sup> Items, 1986 and 1987: "What types of clients referred to you, if any, cannot be served by your agency?" [Responses involving reimbursement issues coded "yes".]

*Abbreviations:* See table 1.

*Sources:* Institute for Health and Aging; DRG Impact Study; 1986 and 1987 Telephone Survey; Home Health Instruments; 1987 Survey of Certificate of Need Policy; Bureau of the Census; state nursing-home directories; varied lists of home health agencies.

This item was asked in 1986 regarding the 1984–86 period (PPS implementation period) and in 1987 regarding 1986–87 (post-PPS implementation period). Differences in refusals are not strong, but they suggest that being both for-profit and a system member increases the likelihood of an HHA refusing a client for payment reasons. Data for 1987 show weak evidence of change in that both for-profit status and system membership increase the likelihood of refusals, but being both does not increase the likelihood proportionately—a pattern that conforms with the

TABLE 3  
 Cross Tab of HHA Client Refusal for Financial Reasons  
 by Tax Status and System Membership

| Agency status        | Clients refused for financial reasons |      |       |                       |      |       |
|----------------------|---------------------------------------|------|-------|-----------------------|------|-------|
|                      | 1984-86                               |      |       | 1986-87               |      |       |
|                      | Yes                                   | No   | Total | Yes                   | No   | Total |
| Nonprofit nonmember  |                                       |      |       |                       |      |       |
| N                    | 21                                    | 17   | 38    | 14                    | 25   | 39    |
| %                    | 55.3                                  | 44.7 | 100.0 | 35.9                  | 64.1 | 100.0 |
| Nonprofit member     |                                       |      |       |                       |      |       |
| N                    | 15                                    | 14   | 29    | 16                    | 14   | 30    |
| %                    | 51.7                                  | 48.3 | 100.0 | 53.3                  | 46.7 | 100.0 |
| For-profit nonmember |                                       |      |       |                       |      |       |
| N                    | 18                                    | 14   | 32    | 19                    | 13   | 32    |
| %                    | 56.2                                  | 43.8 | 100.0 | 59.4                  | 40.6 | 100.0 |
| For-profit member    |                                       |      |       |                       |      |       |
| N                    | 45                                    | 14   | 59    | 37                    | 21   | 58    |
| %                    | 76.3                                  | 23.7 | 100.0 | 63.8                  | 36.2 | 100.0 |
| Total                |                                       |      |       |                       |      |       |
| N                    | 99                                    | 59   | 158   | 86                    | 73   | 159   |
| %                    | 62.7                                  | 37.3 | 100.0 | 54.1                  | 45.9 | 100.0 |
| <i>df</i> = 3        | $\chi^2 = 7.60, n.s.$                 |      |       | $\chi^2 = 7.76, n.s.$ |      |       |

Sources: See table 2.

isomorphism argument. Thus, in 1987, for-profit status increases the likelihood of client refusal among independent HHAs, but not among for-profit system members. Further, a greater likelihood of refusal by HHAs that are nonprofit system members than by nonprofit independents suggests that, within systems, nonprofits behave more like for-profits. Analysis reported below, however, also controls for area measures to provide stronger conclusions about effects of agency factors.

Table 4 reports multivariate logistic regressions. Market factors, HHA tax status, and system membership explain access. Using 1984-86 client refusals to predict 1987 refusals (last column), the latter becomes a measure of change in refusals, except that 1984-86 refusals become a continuity measure. The 1984-86 measure shows no effect on 1986-87 refusals, suggesting that HHAs that previously limited access through

TABLE 4  
Logistic Regression-of-Access Measures

| Coefficient and<br>( <i>t</i> -score) for 1984<br>independent variables | By 1986, agency              |                                 | Refusals for financial reasons  |                                 |                                 |
|---|------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
|   | Increased<br>fees            | Tightened<br>eligibility        | 1984-86                         | 1986-87                         | Change                          |
| Intercept   | -6.945                       | 18.057 <sup>a</sup>             | 17.720 <sup>a</sup>             | 18.734 <sup>a</sup>             | 18.611 <sup>a</sup>             |
| 1984-86 refusals,<br>financial reasons                                  |                              |                                 |                                 |                                 | 0.102<br>(0.22)                 |
| SMSA Herfindahl index   | 26.436<br>(0.79)             | -85.351 <sup>a</sup><br>(-2.71) | -86.249 <sup>a</sup><br>(-2.57) | -82.772 <sup>a</sup><br>(-2.18) | -82.154 <sup>a</sup><br>(-2.09) |
| HHA's per population  | 0.954<br>(0.51)              | -4.152 <sup>a</sup><br>(-2.41)  | -3.364<br>(-1.82)               | -4.494 <sup>a</sup><br>(-2.08)  | -4.508 <sup>a</sup><br>(-2.05)  |
| State HH CON  | -0.921<br>(-1.16)            | -0.363<br>(-0.55)               | -1.311<br>(-1.80)               | 0.017<br>(0.02)                 | -0.021<br>(-0.02)               |
| Percent of population<br>aged 65 or over                                | 0.305 <sup>a</sup><br>(2.16) | -0.347 <sup>b</sup><br>(-2.89)  | -0.275 <sup>b</sup><br>(-2.16)  | -0.370 <sup>b</sup><br>(-2.43)  | -0.367 <sup>b</sup><br>(-2.35)  |
| NH beds per population  | 0.016<br>(1.02)              | -0.001<br>(-0.03)               | -0.031<br>(-1.85)               | -0.050 <sup>a</sup><br>(-2.56)  | -0.050 <sup>a</sup><br>(-2.52)  |
| Agency chain/MFS<br>member  | -0.486<br>(-1.06)            | 0.282<br>(0.65)                 | -0.597<br>(-1.32)               | 1.384 <sup>a</sup><br>(2.43)    | 1.397 <sup>a</sup><br>(2.38)    |
| HHA is for-profit   | -0.211<br>(-0.40)            | -0.439<br>(-0.86)               | -0.841<br>(-1.57)               | 2.345 <sup>a</sup><br>(3.64)    | 2.390 <sup>a</sup><br>(3.65)    |
| Interaction of chain/MFS<br>with for-profit                             | 0.706<br>(0.88)              | 0.330<br>(0.43)                 | 2.378 <sup>a</sup><br>(2.72)    | -2.253 <sup>a</sup><br>(-2.46)  | -2.302 <sup>a</sup><br>(-2.44)  |
| Weighted 1986 client number   |                              |                                 |                                 |                                 |                                 |
| Model $\chi^2 =$  | 20.00 <sup>a</sup>           | 12.40                           | 25.46 <sup>a</sup>              | 32.80 <sup>a</sup>              | 32.31 <sup>a</sup>              |
| <i>df</i> =   | 8                            | 8                               | 8                               | 8                               | 9                               |
| N =   | 159                          | 164                             | 162                             | 146                             | 143                             |

<sup>a</sup> Significant .05 level, two-tailed test.

<sup>b</sup> Significant .05 level, two-tailed test, contradicts hypothesis.

*Abbreviations:* See table 1.

*Sources:* See table 2.

client refusals did not necessarily do so later. There is no evidence that either tax status or system membership affects fee increases or tightening of eligibility. Similarly, regarding refusal of services for financial reasons among nonsystem members in 1984-86, nonprofits do not differ from for-profits, and, among nonprofits, system members do not differ from nonsystem members. Results differ for 1986-87, with for-profits being more likely than nonprofits, and chain than nonchain HHAs, to refuse

services. Thus, by 1987, hypotheses of greater service refusals by proprietary and system HHAs are strongly supported.

Consistent with a hypothesis of organizational isomorphism, nonprofits and for-profits become more alike within systems. Thus, in addition to positive effects of for-profit and system status, an interaction should have a sign opposite to, but of about the same magnitude as, that for for-profit status. Findings for 1984–86 are complex. Although the effect of the interaction is significant, with a sign opposite that for proprietary status, the latter coefficient is not significant. Thus, for 1984–86, only system members show a difference for tax status: both for-profits and system members were more likely than all other HHAs to refuse services. Many nonprofit system members may have been new to system membership in 1986, so had not yet come to act like for-profits (nonprofits having not yet been “socialized” to system norms of refusing services); this does not explain, however, why nonsystem for-profits and nonprofits do not appear to differ.

For 1986–87, the interaction coefficient is negative and of similar magnitude to that for tax status, supporting an institutional isomorphism argument: HHAs within coercive structures remained similar in terms of access, whereas those outside such structures differentiated by tax status. However, the fact that the coefficients for system membership and tax status were not significant in 1984–86, but were for 1986–87, suggests another change between the two periods: HHAs generally became more differentiated along system and tax-status lines. This raises questions about the institutional isomorphism argument in this case.

Negative effects for the Herfindahl suggest that HHAs facing greater market concentration are unlikely to tighten eligibility or refuse services. Effects for HHAs per population suggest that HHAs in more competitive markets are also less likely to reduce access in these ways. Findings for percentage aged are as expected regarding fee increases, but they contradict the hypotheses for all other access measures. It may be that political and normative expectations are more important than demand considerations when HHAs make decisions regarding service refusal and eligibility. As expected, where there are more nursing-home beds, HHAs are less likely to refuse services for financial reasons. Where nursing-home supply is greater, some individuals who could neither pay for nor find coverage for home health services will have entered nursing homes under Medicaid coverage, and thus have not been either referred for home

health services (Swan and Benjamin 1990) or refused services for payment reasons.

By competitive isomorphism, HHAs act alike regardless of tax status under conditions such as greater market concentration and increased competition. Thus, if the Herfindahl index (market concentration) is higher, tax status should have a less positive effect. The interaction of the Herfindahl with tax status is supported for 1986–87 service refusals and for changes between 1984–86 and 1986–87 in service refusals (table 5). The effect is strongly negative, showing less difference between for-profit and nonprofit HHAs where competition is greater. A similar finding emerges if an interaction is entered between tax status and numbers of certified HHAs (not shown in table).

By mimicry, access differences by tax status should converge where either for-profit or nonprofits predominate. Measures of HHA imbalance and its interaction with tax status are entered in table 6 (the interaction of tax status with system membership is excluded because of collinearity). The imbalance interaction has an effect opposite that of tax status, but the signs are the reverse of what was expected, perhaps because of collinearity (the sign for tax-status changes from table 5). so findings offer weak support at best for a mimetic isomorphism argument.

## Conclusions

Findings indicate that tax status, organizational complexity (chain/system membership), and selected environmental factors (competition, concentration, and demand) affect HHA decisions limiting access. Study findings illustrate the importance of local market factors in explaining how HHAs deal with access to care. Findings show that environmental competition (number of HHAs per 1,000 population) and concentration (Herfindahl index) influence access to HHA services. Where there are more HHAs per population, so that any one agency confronts more competitors, and where there is greater inequality of agency size, so that most HHAs compete with a few large agencies, individual HHAs are less likely to refuse services. Thus, where HHAs face more environmental pressures, they tend toward less selectivity in access, and for-profits and nonprofits tend to act more alike. Where there are more nursing-home beds per population, a measure of available supply of the principal alternative service to home health care, HHAs are less likely to refuse services to cli-

TABLE 5  
 Logistic Regression-of-Access Measures:  
 Interaction of Tax Status with Market Concentration

| Coefficient and<br>( <i>t</i> -score) for 1984<br>independent variables | By 1986, agency              |                                 | Refusals for financial reasons  |                                 |                                 |
|---|------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
|   | Increased<br>fees            | Tightened<br>eligibility        | 1984-86                         | 1986-87                         | Change                          |
| Intercept   | -7.197                       | 18.300 <sup>a</sup>             | 17.764 <sup>d</sup>             | 23.494 <sup>a</sup>             | 22.624 <sup>a</sup>             |
| 1984-86 refusals,<br>financial reasons                                  |                              |                                 |                                 |                                 | 0.480<br>(0.90)                 |
| SMSA Herfindahl index   | 32.515<br>(0.96)             | -81.606 <sup>a</sup><br>(-2.56) | -86.195 <sup>b</sup><br>(-2.56) | -78.321<br>(-1.93)              | -72.352<br>(-1.73)              |
| HHAs per population   | 0.934<br>(0.50)              | -4.285 <sup>a</sup><br>(-2.46)  | -3.377<br>(-1.82)               | -6.058 <sup>a</sup><br>(-2.50)  | -6.000 <sup>a</sup><br>(-2.44)  |
| State HH CON  | -0.873<br>(-1.10)            | -0.343<br>(-0.51)               | -1.312<br>(-1.80)               | -0.128<br>(-0.14)               | -0.068<br>(-0.07)               |
| Percent of population<br>aged 65 or over                                | 0.297 <sup>a</sup><br>(2.09) | -0.363 <sup>b</sup><br>(-2.98)  | -0.277 <sup>b</sup><br>(-2.14)  | -0.503 <sup>b</sup><br>(-2.89)  | -0.500 <sup>b</sup><br>(-2.82)  |
| NH beds per population  | 0.015<br>(0.98)              | -0.002<br>(-0.11)               | -0.031 <sup>a</sup><br>(-1.84)  | -0.069 <sup>a</sup><br>(-3.08)  | -0.070 <sup>a</sup><br>(-3.08)  |
| Agency chain/MFS<br>member  | -0.434<br>(-0.95)            | 0.305<br>(0.70)                 | -0.595<br>(-1.32)               | 1.481 <sup>a</sup><br>(2.36)    | 1.605 <sup>a</sup><br>(2.44)    |
| HHA is for-profit   | 0.980<br>(0.89)              | 0.844<br>(0.80)                 | -0.778<br>(-0.70)               | 7.618 <sup>a</sup><br>(4.83)    | 7.998 <sup>a</sup><br>(4.76)    |
| Interaction of chain/MFS<br>with for-profit                             | 0.795<br>(0.98)              | 0.489<br>(0.61)                 | 2.392 <sup>a</sup><br>(2.66)    | -1.749<br>(-1.74)               | -1.896<br>(-1.83)               |
| Interaction of Herfindahl<br>with for-profit                            | 0.795<br>(0.98)              | -21.851<br>(-1.40)              | -1.064<br>(-0.06)               | -80.507 <sup>a</sup><br>(-3.85) | -84.841 <sup>a</sup><br>(-3.82) |
| Weighted 1986 client number   |                              |                                 |                                 |                                 |                                 |
| Model $\chi^2 =$  | 21.58 <sup>a</sup>           | 14.45                           | 25.47 <sup>a</sup>              | 50.86 <sup>a</sup>              | 50.76 <sup>a</sup>              |
| <i>df</i> =   | 9                            | 9                               | 9                               | 9                               | 10                              |
| N =   | 159                          | 164                             | 162                             | 146                             | 143                             |

<sup>a</sup> Significant .05 level, two-tailed test.

<sup>b</sup> Significant .05 level, two-tailed test, contradicts hypothesis.

*Abbreviations:* See table 1.

*Sources:* See table 2.

ents for financial reasons. Thus, where HHAs face greater availability of an alternate service, they tend to be more accessible.

Contrary to hypothesis, with more of the aged in the population (a measure of service demand) HHAs are less likely to have refused services for financial reasons. Perhaps the population density of the old old (e.g., persons 85 or older) would be a better demand variable for HHA ser-

TABLE 6  
Logistic Regression-of-Access Measures: Area Imbalance in Agencies<sup>a</sup>

| Coefficient and<br>( <i>t</i> -score) for 1984<br>independent variables | By 1986, agency                |                                 | Refusals for financial reasons |                                  |                                  |
|---|--------------------------------|---------------------------------|--------------------------------|----------------------------------|----------------------------------|
|   | Increased<br>fees              | Tightened<br>eligibility        | 1984-86                        | 1986-87                          | Change                           |
| Intercept   | -13.843                        | 16.841 <sup>b</sup>             | 9.974                          | 27.314 <sup>b</sup>              | 27.909 <sup>b</sup>              |
| 1984-86 refusals,<br>financial reasons                                  |                                |                                 |                                |                                  | -0.057<br>(-0.13)                |
| Imbalance of SMSA HHAs <sup>a</sup>                                     | -0.196 <sup>b</sup><br>(-3.10) | -0.169 <sup>b</sup><br>(-2.80)  | -0.092<br>(-1.53)              | -0.097<br>(-1.26)                | -0.096<br>(-1.23)                |
| SMSA Herfindahl index   | 56.706<br>(1.73)               | -73.741 <sup>b</sup><br>(-2.29) | -48.690<br>(-1.54)             | -112.900 <sup>c</sup><br>(-2.89) | -115.700 <sup>b</sup><br>(-2.90) |
| HHAs per population   | 2.943<br>(1.53)                | -3.445<br>(-1.89)               | -1.363<br>(-0.75)              | -6.346 <sup>b</sup><br>(-2.78)   | -6.491 <sup>b</sup><br>(-2.80)   |
| State HH CON  | -1.130<br>(-1.40)              | -0.357<br>(-0.51)               | -5.940<br>(-1.40)              | -0.746<br>(-0.85)                | -0.807<br>(-0.90)                |
| Percent of population<br>aged 65 or over                                | 0.514 <sup>b</sup><br>(3.59)   | -0.289 <sup>c</sup><br>(-2.14)  | -0.113<br>(-0.84)              | -0.518 <sup>c</sup><br>(-3.00)   | -0.528 <sup>c</sup><br>(-3.02)   |
| NH beds per population  | 0.042 <sup>c</sup><br>(2.36)   | 0.012<br>(0.65)                 | -0.022<br>(-1.27)              | -0.046 <sup>b</sup><br>(-2.34)   | -0.046 <sup>b</sup><br>(-2.30)   |
| Agency chain/MFS<br>member  | -0.553<br>(-1.38)              | 0.223<br>(0.60)                 | 0.030<br>(0.08)                | 0.549<br>(1.22)                  | 0.546<br>(1.21)                  |
| HHA is for-profit   | 0.911<br>(0.69)                | -3.174 <sup>b</sup><br>(-2.74)  | -1.051<br>(-0.87)              | -1.112<br>(-0.79)                | -1.080<br>(0.75)                 |
| Interaction: agency<br>imbalance/for-profit                             | -0.044<br>(-0.47)              | 0.227 <sup>b</sup><br>(2.72)    | 0.100<br>(1.15)                | 0.195<br>(1.76)                  | 0.195<br>(1.73)                  |
| Weighted 1986 client number   |                                |                                 |                                |                                  |                                  |
| Model $\chi^2 =$  | 35.14 <sup>b</sup>             | 23.63 <sup>b</sup>              | 20.26 <sup>b</sup>             | 29.95 <sup>b</sup>               | 29.49 <sup>b</sup>               |
| <i>df</i> =   | 9                              | 9                               | 9                              | 9                                | 10                               |
| N =   | 159                            | 164                             | 162                            | 146                              | 143                              |

<sup>a</sup> Absolute value of difference of SMSA HHA percentage proprietary minus 50%.

<sup>b</sup> Significant .05 level, two-tailed test.

<sup>c</sup> Significant .05 level, two-tailed test, contradicts hypothesis.

*Abbreviations:* See table 1.

*Sources:* See table 2.

vices; or perhaps other pressures in communities with high densities of people 65 and older mitigate against using refusals as access barriers.

Tax status and system membership do not predict HHA behavior in 1984-86, but in 1987 results predicted HHAs' refusing clients for financial reasons, as well as changing such behavior between 1986 and 1987. Thus, in the later period, independent, free-standing for-profits are much more



likely to refuse services than their counterpart, independent nonprofit HHAs; however, tax status differences disappear when we compare for-profit and nonprofit HHAs that are system members. This finding and those for change over time provide evidence for the isomorphism argument that as nonprofit HHAs become part of complex bureaucratic systems, they are likely to take on characteristics and behaviors of these systems, becoming more like for-profits. There may also be moderating of for-profit behavior or movement over time toward a lower tendency to refuse services (service refusals are lower for all tax and membership statuses in 1986–87 than in 1984–86), perhaps reflecting systemwide decision making or buffering from competitive environments afforded by membership: a process compatible with isomorphism but emphasizing for-profit rather than nonprofit change.

The isomorphism argument is unsupported in 1984–86. Consistent with simple findings in table 4, it was within systems in the earlier period that nonprofits and for-profits differed in service refusals for financial reasons, whereas in 1986–87 it was among system members that there was no difference by tax status. Perhaps in 1984–86, when PPS was implemented and the process of consolidation of HHAs into systems was less advanced, the for-profits in systems were subjected earlier to tendencies to act in similar ways, whereas the tendencies for system-member nonprofits to act like for-profits did not develop until later.

Implications of partial support for the isomorphism argument are fundamental and far reaching. Nonprofit providers have traditionally operated with the mission of providing service to the community and the needy, including much charity care. By contrast, for-profit providers have been expected to operate with an eye to the bottom line. The inroads of for-profits in home health care is important enough in itself; but isomorphism arguments suggest that the effects are more far reaching because nonprofits come to act like for-profits, leading to the conclusion that access will become much more difficult.

Consistent with the neoinstitutional school of organizational theory, we found that a combination of environmental–policy factors has contributed to trends toward for-profit health care (privatization) and greater organizational complexity (rationalization) in home health. Although for-profit status and system membership may be seen as viable organizational strategies to reduce uncertainty and ensure survival, an important issue concerns the behavioral consequences of such organizational changes.

Tests of hypotheses about isomorphism were employed to help us further understand how home health has become structured, the extent of homogenization between different types of HHAs, and the behavioral consequences for specific dimensions of access to care. Findings generally support the research of Schlesinger and associates on hospitals, in that measures of ownership, competition, and multifacility system/chain membership explain access to care in the home health industry. Consistent with the findings for hospitals, we find that by 1987 there was a straightforward relationship in home health between tax status and access, as measured by refusal to serve clients for whom there are payment issues.

We also find a different configuration of results, however. In contrast to Schlesinger and associates, we discover very competitive home health markets to be associated with lower service refusals and to be less differentiated by tax status. System membership also reduces the difference between nonprofits and for-profits in service refusals to clients for payment reasons. This contrasts with hospitals, for which Schlesinger et al. (1987) report that "the influence of system status emphasizes the differences due to ownership." Our findings may vary from those of Schlesinger because of the dynamics of the different health care industries or as a result of changes occurring over time. Schlesinger's study was for the 1984 period, whereas ours covered both periods: 1984-86 and 1986-87; we found our major differentiation by organizational characteristics for the later period. Further investigation is needed into the changing structure of the home health industry and the impact of tax status and system membership on access and other home health issues.

Findings suggest unanticipated, latent consequences of policy that fosters for-profit status and integration into systems. Public policy and changes promoting home health restructuring that favors selected types of HHAs (for-profit and system members), and isomorphic processes that reduce the differences between nonprofit and for-profit HHAs, lead to questions about the consequences for particular population groups. An important empirical question is the extent to which our findings may be explained by a cultural shift both in the expectations and the values of nonprofit organizations in the context of market rhetoric that marked the 1980s and in the policies governing the distribution of state resources. Schlesinger et al. (1987) and others have appropriately described the "subtle but pervasive shift in the expectations and values governing the relations between medical providers and the communities in which they are located"

as one of the most fundamental aspects of health care privatization. The dramatic structural changes in the health care system and the deep institutional shifts at the ideological and meaning level require policy makers who are concerned about access to home health care to consider explicit policies for encouraging or protecting charitable behavior. These should include ways to reward HHAs that accept a "disproportionate share" of needy but uninsured patients. We agree with Schlesinger et al. (1987) that it behooves policy makers to "take a more active role in defining what is expected of health providers in a community."

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