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ELDERCARE IN THE UNITED STATES: INADEQUATE, INEQUITABLE, BUT NOT A LOST CAUSE

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ABSTRACT

Eldercare, like other forms of care work, is often taken for granted and undervalued. The burdens as well as the failures of providing care for the elderly are often borne disproportionately by women. This paper documents inequality of access and low quality of care for the elderly in the United States. It argues that public funds used to subsidize nursing homes are poorly spent and that profit-maximizing competition in the nursing home industry adversely affects the quality of care provided. In seeking to address these problems, policymakers can learn important lessons from several different sources. The experiences of several European countries, current regulatory efforts in the state of Massachusetts, and more decentralized volunteer efforts to promote humane visions of eldercare all offer some hope for the future.

KEYWORDS

Eldercare, care work, nursing homes, long-term care, public policy

JEL Codes: J14, I38, J16

INTRODUCTION

Eldercare is one of many kinds of care work that feminist economists have explored (Marianne Ferber and Julie Nelson 1993; Nancy Folbre 2001; Jane Jenson and Mariette Sineau 2001). It takes place both inside and outside the formal market, and many aspects are difficult to measure and quantify. Eldercare is embedded in the values of every culture and imbued with meanings that range from respect to denial, from reciprocity to anger, from family-based obligation to humanitarian privilege (Geoff Schneider and Jean Shackleford 2001: 80–1; Heying Jenny Zhan and Rhonda J. V. Montgomery 2003).

Problems with the provision of eldercare in the United States are growing. The supply of family care for the elderly is likely to decline. The overall quality of paid eldercare is low, and access to it is uneven (Susan Eaton 2000). Low-income elderly, who are predominantly women, cannot rely on family care and often end up in nursing homes where the quality of

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care is woefully poor. The structure of the nursing home industry, in which firms are forced to engage in competitive cost cutting in order to cope with inadequate federal subsidies, deserves much of the blame for low-quality service.

This paper explores and responds to these mounting problems with the current system of eldercare. It looks for lessons from the countries of northwestern Europe, which provide better eldercare than the US. Even given the current institutional environment within the US, there is potential for improvement through state regulation and participation. Additionally, a number of well-organized volunteer efforts provide inspiration for more radical change in the US.

THE SUPPLY OF ELDERCARE

Much of the responsibility for long-term care continues to fall on families, and it is largely women – many of them over the age of 55 – who provide such care. Several factors are likely to reduce the future pool of women available as caregivers: women's increasing participation in the workforce, the restructuring of families that follows divorce, and increasing geographic mobility. Furthermore, growing awareness of the personal costs of assuming care responsibilities is likely to have an increasing deterrent effect.

Men's shorter average longevity often spares them from the worst consequences of aging, such as being institutionalized, poor, sick, and dependent upon others. A large majority of elderly US nursing home residents are widows who cared for their late husbands at home, often with help from home care services or children (Brenda Spillman, William Spector, John Fleishman, and Liliana Pezzin, 2000). When their husbands die, relatively few surviving wives have the resources to pay for their own home-based care, which seldom provides for 24-hour needs for those without a full-time caregiver at home.

Currently, 85 percent of eldercare in the US is provided free of charge by family members and friends, primarily women (US Administration on Aging 2002). The National Alliance for Caregiving estimates that 73 percent of family caregivers are women, most of them employed (1997). Women are also a majority of informal caregivers in Europe. Female unpaid family workers represented nearly 70 percent of the total between 1990 and 1997 in Austria and the United Kingdom, more than 80 percent in Germany and the Netherlands, and 90 percent or more in Denmark and Luxembourg. Only in Ireland (40 percent), Portugal (58 percent), and Finland (32 percent) was the percentage below 60 percent (United Nations Human Development Report 1999). Women also provide the bulk of eldercare in traditional cultures like China, where unpaid daughters and daughters-in-law often provide hands-on assistance, while sons may assume some responsibility for financial support (Zhan and Montgomery 2003).

In the US, informal eldercare may involve inviting an aged parent or relative to live in one's home or building a "mother-in-law" apartment where she can live without sharing fully in family space on a daily basis. It may involve moving an elder to a nearby apartment or turning down opportunities for career advancement that might require relocation away from an aging relative. Or it may mean just being a "good Samaritan" and bringing meals, doing shopping, taking an elderly neighbor to the doctor's office, or helping with other necessary errands. Sometimes an older person, with or without the help of family, hires an informal caregiver who visits regularly to help when she is unable to care for herself. These informal caregivers are often hired "off the books" so families can avoid paying taxes, worker's compensation, unemployment insurance, and Social Security payments or benefits for the worker.

According to the US Department of Labor, 60 percent of adult women were part of the paid labor force in 1997. In the same year, nearly one in four households provided some care to elders, typically by middle-aged employed women providing an average of 18 hours of care a week to a nearby parent for an average duration of 4.5 years. A study by Metropolitan Life Insurance Company (MetLife) estimated the net cost in lost productivity to business at a minimum of $11.8 billion a year (Metropolitan Life Insurance Company 1997: 4). The $11.8 billion calculation makes clear what is most valued (business productivity), while it simultaneously provides an estimate of the value of part of the unpaid work of the women involved. Yearly replacement costs for employees who quit their jobs to care for elders are estimated at $4.9 billion, absenteeism at $398 million, partial absenteeism at $488 million, workday interruptions at 3.76 billion, eldercare crises at $1.1 billion, and supervising caregivers at $880 million.

Costs to caregivers are substantial. They sometimes forgo promotions, overtime, and other work opportunities to take care of relatives. The term "the sandwich generation" was coined to describe mostly middle-aged women taking care of parents on one side of the generation gap and children on the other. Studies have documented the stress that such responsibilities can impose (Elaine Brody 1990). The numbers from MetLife omit several difficult-to-estimate costs, including increased mental health and healthcare costs for caregivers and the impact of leaves of absence and reduced work hours on career advancement.

The MetLife estimate of $11.8 billion should be viewed as a lower bound, since it only includes employed people helping with multiple significant daily tasks and excludes 8.7 million employed people who help with more basic tasks; if they were included, the total estimated costs would reach as much as $29 billion a year.

The US-based National Alliance for Caregiving offers much higher estimates. By their calculations, American family caregivers provide $257 billion in free care annually. Compare this figure with $32 billion per year

spent for home-based paid care and $92 billion per year for nursing home care in the US. In the United Kingdom, family caregivers (also known as "carers") provide free care worth US$86 billion, about the same amount the UK spends on its national health service (National Alliance for Caregiving 2002).

Women are also the primary paid caregivers for the elderly in the US, often going into the field because of previous experience caring for an older relative at home (Susan Eaton 2002). Fully 90 percent of direct care workers employed in US nursing homes are women, disproportionately women of color with a high school education or less (Robin Stone and Joshua Wiener 2001). Certified nursing assistants (CNAs) provide most hands-on care to residents in institutional settings. Home health aides and personal care aides working in the community are also mostly women. The experiences of these workers have been the subject of intense scrutiny lately because of a predicted massive workforce shortage that could entail an 11 percent vacancy rate and a 76 percent turnover rate (Barbara Frank and Steven Dawson 2000; American Health Care Association 2005). At least 42 of the 50 states have created task forces to address actual and potential workforce shortages (Paraprofessional Healthcare Institute and the North Carolina Department of Health and Human Services 2002).

Inadequacy and inequality in eldercare

In the US, unlike many other advanced industrial countries, the social safety net is thin and offers no guarantee of long-term care for the elderly or disabled. While everyone over 65 years of age is eligible for Medicare, this social insurance only covers acute illness and hospitalization, sometimes with a short rehabilitation stay in a nursing home. But despite the existence of some pilot projects, no home or community-based care is provided as a universal benefit. Only extremely poor people (with assets less than $2,000) are eligible for Medicaid, a state-based program that pays for a bare minimum of institutional long-term care. Most Americans appear to be badly informed about this basic problem; few have purchased private long-term care insurance or saved enough to pay for institutional care on their own. Yet projections indicate that as many as two-thirds of all adults reaching 65 will require such care at some time in their lives (Walter Cadette 2003).

Paid home and community-based care

A patchwork system of paid home and community-based care supplements informal care. Home health and home care agencies can provide either personal care, which involves light housekeeping, bathing, and perhaps cooking, or health-related care, which includes assisting with medication,

rehabilitation, changes in dressing, or other necessities. Medicare pays a portion of the costs of health-related care under strict conditions, such as when the person covered is only able to leave her home for visits to a doctor. Since 1999, new payment systems have reduced the provision of this form of care (Nelda McCall and Jodi Korb 2003). A limited amount of Medicaid-paid care is provided to poor elders under state waivers when this avoids more expensive institutional care. Most home and personal care is paid "out of pocket" either by the older person needing care or by her or his family.

Most US states are trying to redirect public resources away from long-term institutional care and toward home and community-based care, but they are concerned about the "woodwork" effect: latent demand for such services far exceeds the feasible supply if eligibility requirements are loosened. Although a few innovative experiments are under way, such as a home health cooperative in New York City (Cooperative Home Care Associates 2003), most non-nursing home health jobs are poorly paid and offer little job security, training, or even guaranteed hours. Many home health companies do not even pay for transportation between clients' homes, much less provide their employees health insurance.

Formal eldercare

Formal eldercare is provided in "assisted living" facilities or nursing homes. A few "private pay" facilities admit only wealthy people who can afford $60,000 in minimum annual costs, but 95 percent of US nursing facilities participate in the two public programs Medicare and Medicaid. Relatively few elderly can afford private care, and most live in publicly subsidized nursing homes that are run for profit.

"Assisted living" facilities are apartment-like dwellings where elders can get limited help with some activities of daily living (ADLs), reminders to take medication, and usually at least one hot meal a day. Demographic projections led many businesses to consider these a future profit center, but a number of corporate chains, including Marriott and Hyatt, have encountered sizable unanticipated problems related to "aging in place." These problems occur when elders need more than occasional assistance or require more regular nursing or healthcare than these facilities normally provide. Many elders are so fearful of nursing homes that they resist conceding that they need additional care, and it is hard to force people out of housing they rent or own. The exclusion increases the price of assisted living facilities, which in turn reduces the number of elderly who can afford such facilities.

Continuing care retirement communities (CCRCs) offer the elderly opportunities to move through various levels of care as their needs increase, often requiring that elders be ambulatory and reasonably healthy

before they enter. Most of these CCRCs, even religious nonprofits, require deposits that run to the hundreds of thousands of dollars and are forfeited to the organization after some period of time, as well as a monthly living fee covering meals and basic services. While these communities offer the most peace of mind, they are available only to the relatively small numbers of elderly that can afford them.

The elderly living in 17,000 nursing facilities (NFs) in the US are most likely to be poor, whether or not they met that description when they entered. Two-thirds of the 1.7 million mostly female residents in US nursing facilities are eligible for Medicaid, which pays for just over half of nursing facility costs. While requirements vary by state, Medicaid eligibility typically means that elders may not possess more than $2,000 in assets (sometimes excluding a home if a spouse is still alive). Also, any income they may have from US Social Security or other sources is paid directly to the facility, where charges for a single resident now average $158 a day for a semi-private room, or $57,670 a year, and much more in some high-cost states like New York and Alaska (Metropolitan Life Insurance Company 2003: 4).

Facilities prefer to admit residents who can pay their own way for some time to come, but they seldom enjoy this opportunity. If middle-class elders arrive in a nursing facility with typically modest financial resources they quickly spend down their funds (at $51,000 per year, on average) and convert to Medicaid status. The worst nursing facilities tend to be those whose populations are more than 75 percent Medicaid-financed (although there are some exceptions, such as the Hebrew Rehabilitation Center for the Aged in Boston, Massachusetts). So-called "Medicaid mills" rely on minimal staffing, turn over Medicaid clients rapidly without providing personal or individual attention to their needs, and often defy federal regulations. Nursing homes face a cost squeeze: direct public payments to nursing facilities, not including individuals' Social Security payments, cover only about 61 percent of total costs (Cadette 2003).

Elders without family members who are willing and able to care for them at home often have a particularly hard time coping with serious illness. Because of cost-cutting in Medicare and other health programs over recent years, hospitals have incentives to shorten the stays of their patients, and often send elderly people "quicker and sicker" to nursing facilities, where average acuity of needs has increased substantially over the last ten years. According to the Online Certification and Reporting System of the Centers for Medicare and Medicaid Services, more than 45 percent of nursing home residents in 2004 suffered from dementia (American Health Care Association 2005).

In sum, formal eldercare in the US fosters even more social inequality than informal care, splitting old persons between "private payers" and the poor (or soon to be poor).

Nursing home quality

The quality of home and informal care is difficult to assess unless it is delivered in a community setting that can be observed or monitored. The quality of nursing home care is difficult to assess for similar reasons, but some indicators are provided by regular inspections by state surveyors who inspect facilities at least once every fifteen months, looking for regulatory violations. Regulations in the US generally focus on indicators of basic clinical care and health rather than quality-of-life concerns.

Problems that cause actual harm to residents or place them in immediate jeopardy have been documented in at least one-quarter of all facilities (US General Accounting Office 2003). Some care problems, such as severe weight loss and serious avoidable pressure sores, are understated by survey agencies and are not included in this estimate. A study in California, the largest state in the US, showed that many elders are dying of preventable problems including untreated infections, repeated falls, and even malnutrition and dehydration (US General Accounting Office 1998).

A shocking number of complaints a year are logged in the US from consumers, their families, and ombudspersons about the quality of nursing home care (US General Accounting Office 2002). The Department of Health and Human Services (DHHS) recently released a report showing that 95 percent of the nation's nursing homes did not meet the staffing threshold below which harm could be shown to occur for residents (US Center for Medicare and Medicaid Services 2001). Yet the administration of George W. Bush decided not to implement the report's recommendations for mandating increased hiring of nursing assistants and nurses, but rather attempted to create more efficient markets by posting information on nursing home quality on a government website (Department of Health and Human Services Secretary Thompson's letter to Congress concerning US CMS 2001; for a response, see Paraprofessional Healthcare Institute and American Federation of State, County, and Municipal Employees 2001). A coalition representing consumers, labor, providers, and the National Citizens' Coalition on Nursing Home Reform (NCCNHR) has documented serious quality and access problems in the nursing home industry and has proposed potential policy solutions. NCCNHR affiliates have focused on quality issues with consumers in every US state (see http://www.nccnhr.org).

The structure of the nursing home industry

The US primarily uses public funds (Medicare and Medicaid plus Social Security) to fund a mostly private, for-profit industry. About 67 percent of US nursing homes are for-profit, 25 percent are not-for-profit, and 8 percent are publicly owned (Eaton 2000). The federal government has

delegated to states the power to set specific benefit levels, beyond a bare minimum, and to monitor basic safety and quality standards.

One major problem with ensuring quality of care is, of course, the limited information and consumer choice that exist in this environment. Nursing facilities average 80 percent or higher occupancy rates; the highest quality ones fill quickly and have long waiting lists. As a result, few consumers are able to exercise much choice. Many elderly people transferring to nursing home facilities after a short hospital stay must go wherever they can find a bed. Most states have limited or banned the construction of new nursing home beds, since they would fill up nearly immediately if built, costing the public sector more. Also, it is difficult and dangerous to move elders after they have settled into a facility, so the initial choice is usually the last, allowing little room for trial and error.

Family members may or may not provide a check on quality; too often they live far away and visit only rarely. Finally, the health status of older residents is poor to begin with and tends to worsen unless they only have a short rehabilitative stay. With more than 50 percent of nursing home inhabitants suffering from dementia, the "consumers" themselves are often not able to make their needs understood or to complain about poor conditions. While direct physical abuse is relatively rare, it does occur, and some observers would say that emotional abuse is more frequent though harder to document. Probably the most severe problem is the poor quality of day-to-day conditions that results from inadequate staffing.

Nursing facilities in the US are not just generally unpleasant places to live and die; they are also unpleasant places to work. Wages for direct care workers average under $10 an hour, not enough to put a single mother with one or two children over the poverty line even if she is working full-time all year. Turnover among certified nursing assistants has been documented as more than 100 percent per year and is seldom lower than 30 percent per year (Eaton 2002). Not surprisingly, turnover among administrators and directors of nursing is increasing. Nursing homes are among the least safe workplaces in the US, even worse than construction sites and coal mines. Major complaints include back injuries from lifting and abuse from residents (Service Employees International Union 1999). Nursing facilities offer few benefits to their staffs, whose members are disproportionately women of color and immigrants, typically with low levels of formal education. Only about 10 percent of nursing facilities are unionized (more in highly organized areas like New York City).

Despite their efforts to cut costs, few nursing homes are profitable. Seven of the largest nine for-profit nursing home chains experienced bankruptcy in the last several years, in part as a result of tighter regulations on the amount of physical therapy and real estate transaction costs that can be reimbursed. Nursing facility operators blame many of their difficulties on

inadequate government reimbursement and the precarious conditions experienced by their frontline staff (Barbara Bowers 2001).

POLICY ALTERNATIVES

Many countries do a better job than the US in providing for the elderly, although none provides ideal conditions. Advocates for improved eldercare in the US should demand more generous public provision but should also try to explain the limitations of market-based approaches and search for ways of improving eldercare quality.

Public provision

In many Western European countries, policies toward the elderly are designed to provide public support for living at home and aging in place. These policies are complemented by generous health and housing policies. The best examples of entitlement to independence and autonomy while receiving necessary care can be found in the Nordic countries, where governments provide support for elder home care, sometimes with 24-hour-a-day coverage. Sweden provides health and long-term care to all citizens based on need, offering an allowance to elders (or a caregivers' salary to the caregiver) comparable to the salary a state employee would earn, including vacation and pension benefits. Both Israel and Sweden give generous benefits to family members to take leave from paid work to care for an older family member, and long-term care is part of Israel's state-funded social insurance plan (National Alliance for Caregiving 2002: 6–7). Australia has passed a Home and Community Care (HACC) Act that provides respite and support services to caregivers and subsidizes nursing home care so the maximum payment owed by an elder or their family is capped at US$15,000 a year.

In Japan, where life expectancy is the longest, and the proportion of elders the highest in the world (projected to reach 26 percent by 2020), about half of all elders live with family members. Still, in 2000 Japan established the National Long-Term Care Insurance law, which relies on taxes and 10 percent co-payments from beneficiaries to provide residential or in-home care to all persons over 40 years of age who need it (National Alliance for Caregiving 2002: 8). Even in a very traditional culture where most married women do not work at career-type jobs and filial piety is valued, the government has established a right to needed care, whether at home or in an institution.[1]

In the UK, care in nursing homes is free to all. Home caregiver support is far more extensive than in the US, although it is sometimes means-tested to reduce total costs. Even Canada, a country that excludes nursing homes from national health services, provides affordable alternatives for assisted

living. Seniors are also entitled to a social insurance payment that allows them more freedom of choice, although the amount of tax subsidy or caregiver support varies by province (National Alliance for Caregiving 2002: 8).

Weaknesses of market-based provision

The case for increased public provision of support for the elderly in the home and community rests on inherent weaknesses of market-based provision. In a wide-ranging essay on optimal contracts for health services, economists Karen Eggleston and Richard Zeckhauser emphasize the problems caused by limited information and the lack of consumer sovereignty (2002: 64–5). These problems suggest that a profit-oriented system can be problematic.

New economic models are needed to conceptualize the work of physical and emotional care for frail elders. As Arlie Hochschild noted many years ago in *The Managed Heart* (1983), corporations can try to make employees "act" friendly and happy, but this is hard on employees if it requires them to act in ways contradictory to their true feelings. In nursing home care, genuine relationships have remarkable healing qualities, but forced or artificial ones seem to burden caregiver and recipient alike.

Both the inputs and the outputs of care work are difficult to measure and monitor. Care work creates new bonds of social obligation and concern that enhance its value but also keep the "carer" feeling obligated to the person rather than to the job. This may mean that caregivers will work for lower wages than they should given the value of their work, and it may also mean that they perform significant unpaid work, resulting in inequities that penalize caregivers. In the long run, potential caregivers may learn to avoid care responsibilities because they create such emotional vulnerabilities (Paula England and Nancy Folbre 2003).

In the US, achieving accountability for private providers of care services who use scarce public dollars has been very difficult. Monitoring daily interactions is impossible, and occasional surveys, while helpful, do not resolve operational problems leading to repeated serious threats to residents' health and well-being. So far, the US government has attempted to regulate eldercare mainly through outcomes-based regulation and the prohibition of certain practices or conditions (cold food, unsafe hallways, insufficient hydration, etc.). But most consumers and even the government oversight agencies see major problems with this approach. Providers accurately complain that they are the most regulated industry in the US, with the possible exception of nuclear power, yet poor and even dangerous conditions continue to plague the industry.

Regulatory alternatives

Given market failures, how can public policy promote positive organizational change at the level of the individual facility or the industry as a whole? One encouraging example is provided by the state of Massachusetts, which inaugurated a Nursing Home Quality Initiative in 2000. The legislation initially had three features: (1) a wage pass-through to give providers more capacity to increase frontline worker wages ($45 million), (2) a scholarship fund for training new certified nursing assistants to come into the field ($1 million), and (3) a career ladder initiative designed to increase skills and retention among caregivers, to provide them with a way to move up occupational ladders in nursing facilities, and to encourage organizational "culture change" promoting more individualized, higher quality care ($5 million). The Commonwealth Corporation, a quasi-public organization that provides a variety of services to Massachusetts businesses, administered the third feature, the Extended Care Career Ladder Initiative (ECCLI). The Massachusetts legislature has refunded ECCLI each fiscal year through 2004, despite serious lapses in funding during state budget delays in 2001 and 2002.

Evaluations of ECCLI have shown that the program was successful in training hundreds of frontline workers in skills related to dementia care, death and dying, basic adult education and literacy, and other areas related to improving patient care (Susan Eaton, Claudia Green, Randall Wilson, and Theresa Osypuk 2001; Randall Wilson, Susan Eaton, and Amara Kamanu 2003). The program also encouraged organizations to create slightly higher-paying jobs (sometimes called Certified Nursing Assistant or CNA 2 and 3) that involved mentoring, supporting registered and licensed nurses, and sometimes doing more skilled work. However, these jobs paid only about 30 to 50 cents an hour in higher wages, which was insufficient to improve the lives of the CNAs involved. Although adoption of the program was associated with increased retention and reduced turnover, it was hard to identify its specific effects independent of macroeconomic trends (Eaton *et al.* 2001; Wilson *et al.* 2003). Changes in organizational culture were more difficult to perceive and measure, although efforts to attribute specific quality-of-care outcomes to particular workforce improvements continue.

Does ECCLI offer potential for improving the quality of care in the US? Although the program includes clearly mandated requirements for participation and expected outcomes, it also allows for a certain amount of flexibility in regard to program development and implementation at the facility level. Such management-based regulation "directs regulated organizations to engage in a planning process that aims toward achievement of public goals, offering firms flexibility in how they achieve public goals" (Cary Coglianese and David Lazer 2002). This decentralized form of regulation differs from technology-based (in which organizations are

directed how to implement a program) or performance-based (in which organizations must achieve desired outcomes) regulation.

Management-based regulation seems appropriate for ECCLI because each nursing facility or home healthcare agency possesses a unique CNA population – differing in nationality, primary language spoken, and years of experience, among other variables – that requires flexibility in program and curriculum development. Allowing local, on-site management and leaving decisions up to those affected by the regulations is also in line with an assisted living philosophy that advocates choice. Yet the implementation and evaluation of the program has not yet resolved the problem of achieving accountability for the larger outcomes of promoting personal relationships between staff and clients and enhancing quality of life for elders and employees.

Encouraging and developing best practices

Overall, the 17,000 nursing facilities in the US have shown little eagerness to improve their management or explore new innovations. Most of the care offered is of a type that can be considered custodial, at best. However, some exceptions are emerging, as new, largely volunteer organizations try to encourage "regenerative care" (Eaton 2000, 2002). These include Wellspring (Susan Reinhard and Robin Stone 2001), the Eden Alternative (2005), and the Pioneer Network (2005).

One management reform advocated by the Pioneer Network involves "consistent assignment" of aides to residents, rather than floating or rotating assignments, so that genuine relationships can develop between people, and so local knowledge of daily preferences can be honored and retained" (The Pioneer Network 2005). The Pioneer Network is trying to redefine the very way "old age" and "eldercare" are understood. Their eleven principles include statements that aging is another life stage; that growth is not only possible, but also necessary in this life stage, as in all others; that elders are people to learn from; and that people need to give and receive care. Becoming a "pioneer" caregiver is a journey, not a destination, promoting the kinds of caring interactions between people that are seldom to be found in grim and reeking nursing homes.

So far, the Pioneer Network is only a small, underfunded, voluntary social movement relying on the extraordinary commitment of talented individuals. However, two private foundations, Atlantic Philanthropies and Robert Wood Johnson, have recently teamed up to fund demonstration projects and applied research studies, inspired in part by Pioneer Network culture change initiatives, to put the concept of "Better Jobs and Better Care" into practice (2005). Grantees representing coalitions of consumer advocates, long-term care workers, provider organizations, and various state agencies in Iowa, North Carolina, Pennsylvania, Oregon, and Vermont will

implement innovative changes in policy and practice designed to build a stable, high-quality workforce and address problems of high turnover and worker shortages.

These efforts are directed only at the tip of the iceberg. It is unrealistic to expect highly institutionalized organizations to "change their cultures" based on a few thousand dollars in training funds, or to mandate that managers do a better job of building positive relationships between staff and elders. Moving the entire industry toward "regenerative communities" and high-quality care will require even more public policy resources than Massachusetts' ECCLI program. Still, these efforts could help build the sense of possibility needed to mobilize widespread support for change.

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NOTE

1 In China, as Zhan and Montgomery (2003) note, the increased number of women workers since the Cultural Revolution has meant that not only sons but daughters are considered financially responsible for aging.

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